Medical Times.

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THE CANADA

MEDICAL RECORD.

A Monthly Journal of Medicine, Surgery and Pharmacy.

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College of Physicians and Surgeons,

PROVINCE OF QUEBEC.

Biological & Medical Serials

Provincial Medical Board—Semi-Annual Meeting.

The Semi-Annual Meeting of the Board of Governors (Provincial Medical Board) of the College of Physicians and Surgeons of the Province of Quebec, will be held on WEDNESDAY, the 28th Sept. next, at 10 a.m., in the Laval University, Quebec. Candidates for examination or for license must send their certificates of admission to the study of Medicine, also the fee for the license, $20, *at least ten days previous to the meeting*, to either of the undersigned Secretaries. Candidates must bring their Diplomas with them to the meeting.

A. G. BELLEAU, M.D.,
Quebec.
F. WAYLAND CAMPBELL, M.D.,
Montreal.

MONTREAL, April, 1887.

College of Physicians and Surgeons,

PROVINCE OF QUEBEC.

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Provincial Medical Board—Preliminary Examination for admission to the Study of Medicine.

The examination for admission to the study of Medicine will be held on THURSDAY, the 22nd Sept. next, at 9 o'clock a.m., in the city of Quebec, at the Laval University.

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THE CANADA MEDICAL RECORD.

VOL. XV. MONTREAL, JULY, 1887. No. 10.

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Original Communications.

ON SOME FORMS OF HYSTERIA.

BY GEORGE ROSS, M.D.,

Professor of Clinical Medicine, McGill University.

(*Read before the Medico-Chirurgical Society of Montreal.*)

We are all fully alive to the freaks and vagaries of that strange disease, *Hysteria*, and, in anomalous cases, should be on the alert for the detection of this underlying element. The usual manifestations of hysteria are so striking, so well understood, and so easily recognized, that when they exist, they give an impress to the symptomatology that cannot escape the medical observer. But when these are wanting, the symptoms may very easily be, and often are, mistaken for those arising either from *organic* disease of the nervous system (central or peripheral), or from disease of very various organs and structures. It is, too, a matter of common observation that persons suffering from the graver forms of hysteria may never have presented any of the common manifestations just alluded to, and this valuable aid to diagnosis is frequently wanting. This point is worth establishing, because it is within my experience that the absence of a history of globus, or of convulsions or fainting attacks, or retention of urine, etc., is often brought forward as an argument against the hysterical hypothesis in a doubtful case. To reach a satisfactory diagnosis in these cases, it is of special value to consider the whole of the symptoms together, taking in the entire picture made by these, and studying them from the standpoint of their possible explanation as a whole—for the anomalous character of the entire group of symptoms often forms the strongest argument in favor of hysteria; and mistakes are often made by want of due consideration of this procedure, where any two or three of the symptoms, taken apart from others, might readily indicate an entirely erroneous conclusion.

As hysteria is pre-eminently a disease of the female sex, it is mainly amongst girls and women that we are so apt to suspect its existence. That it occurs amongst boys and men will be admitted by any medical man to whom you put the question; but you will generally find that the cases they have seen are limited to perhaps one or two in which the common phenomena—emotional fits, or globus, or palpitation—have occurred. So rare is it to observe hysteria gravior in the male. But it does show itself sometimes, and may then be the source of grave alarm on the part of both friends and medical attendants. I have met with several examples of the kind within the past year, and to illustrate this point, select two cases from the hospital record:

CASE I.—E. P., aged 31, telegraph operator, admitted 27th September, 1886, complaining of spitting blood, severe vomiting, and diarrhœa. Family history good. Patient has always enjoyed good health until 4th July, 1884, when, whilst on a sea voyage, was suddenly thrown from his berth, striking his head against a marble wash-stand. Remained unconscious for half-an-hour, and no bad effects followed until twenty days after the accident, when he had a fit, described as follows: Unconscious; frothing at the mouth; tongue

bitten; limbs quiet. Fit lasted half-an-hour, after which he felt tired and sleepy. These fits came on every second day about 11 a.m., and were preceded by a feeling of "wishing to be alone." The fits continued for three months, and at the end of this time patient entered a hospital in Dublin, where the surgeons decided to trephine; but patient objected to this, and he was given small doses of calomel for two hundred consecutive hours. The result of this treatment was severe ptyalism and complete cessation of the fits. Has had no recurrence since. Nine months later had occasional attacks of cholerine for two months whilst in Marseilles. In December, 1885, began to complain of an easy, painless, non paroxysmal cough, generally worse in the morning, attended with a small amount of greyish-colored and tenacious sputa. In the intervals of coughing, patient sp at up bright red, frothy blood, varying in quantity from a teaspoonful to three tablespoonfuls, and, he says, as much as 20 ounces upon one occasion. Had night sweats; no diarrhœa; lost flesh somewhat. Remained in a hospital in Paris for two months, where, under the use of the hot hammer and blisters to the chest, he improved very much, and returned to England. Three months later, through having "caught cold," patient had a return of the above symptoms in about the same degree of severity. He now entered the Brompton Hospital, where, under treatment (cod-liver oil, porter, and nourishing diet), he improved so much that at the end of five weeks he left the hospital able to resume his usual occupation. Shortly after there was a return of all his previous symptoms in a slighter degree, and he entered the Victoria Park Hospital. Here, under a similar course of treatment, he improved much in health and strength, and continued to do so until 26th September, 1886, when after just arriving in Montreal was seized with, he says, a severe attack of diarrhœa, stools being watery, yellow, and streaked with blood, the passage of each stool being attended with a good deal of pain and tenesmus; complained also of abdominal cramps and vomiting, the ejecta consisting of food taken. Had a slight attack of spitting of blood. No cough nor thoracic pain. These symptoms were preceded by chills and feverishness. Upon admission, these were the symptoms complained of by patient; but, upon examination, the stools passed were quite normal in appearance, and he had no attack of vomiting.

Examination—Of average height; weight 118 lbs.; sparely, though well-built; anæmic; dark complexioned; skin warm and moist; muscles not wasted; no evidence of injury to head; no evidences of syphilis; nails not incurvated; tongue pale and moist, coated in centre with slight white fur-edges indented. Pulse 84, regular, and of good volume. Respiration 18, regular. Temperature 99°. Physical examination of the heart and lungs is negative. Examination of the larynx by Dr. Major reveals nothing abnormal. Dr. Johnston's report upon the sputum (?) is as follows: "A dark-brown fluid, odor aromatic, contains traces of food, considerable number of fat globules, and numerous, epithelial scales, also a few mold filaments; not examined for bacilli, as none of the usual elements of sputum were found; no blood-cells to be seen in specimen." Urine 52 ozs., very pale color; no deposit; 1022; no sugar, no albumen.

During patient's stay in the hospital his chest was frequently examined, with negative results; the spurious expectoration was subjected to rigid examinations, with the same result as that at first arrived at. He was closely watched for these attacks of spitting of blood, but never could he be caught in the act. The symptoms complained of disappeared upon admission; his appetite was good, the bowels regular, slept well, gained in weight, and nothing unusual developed until 30th October, when, at 2 p.m., he was seized with violent and excessive pain in the umbilical region, and upon examination, even the slightest touch caused excruciating pain and made him cry out. The position assumed was as follows: Recumbent posture; left arm held closely to the body and forearm flexed to a right angle; fingers of left hand strongly abducted from the median line and semi-flexed; the left thumb was firmly adducted and flexed to a right angle. The fingers and thumb were easily straightened, but soon flew back to their original state. The act of moving the fingers apparently pained him very much. The right upper extremity was not at all affected. The lower extremities were markedly rigid and extended. Feet extended and all the toes pointed forwards, except the left great one, which was bent backwards and almost touched the dorsum of the foot. Unexpected tickling or pinching the lower extremities would cause the existing rigidity to pass off, and the legs would suddenly be drawn up. When attention is drawn to it, no amount of tickling or pricking with a pin would cause any starting of the extremities or give evidence of pain. Patient

wrongly locates the site of any touch or irritation. Sight and hearing unaffected. Pulse 60, regular; respiration 18.; temperature 98°. This condition continued for about one hour, and at the end of this time had resumed his natural state. In the evening of the same day had a similar attack; but in addition to the foregoing symptoms, there was, as he said, "complete inability to see any objects or even to distinguish light from darkness;" the sense of smell and taste were also absent, as he did not give the slightest evidence of perceiving a strong solution of ammonia held closely to the nostrils, nor of tincture of assafœtida placed on the tongue. Patellar reflex was present, and to a marked degree on the left side. Pulse 70, regular; respiration 18; temperature 100°. Patient said he had a fit during the night of a character similar to those he had when in a hospital in Dublin. Next day all that remained of his symptoms was analgæsia above the right eye, over an area of 2 × 3 inches. His gait had also changed, for when walking he placed the right foot in advance of the left, and rested on the right whilst the left was lifted in a rigid state close to the other foot. At times when walking in this manner he would tend to fall to the left side. Two days later all symptoms had entirely disappeared, and the gait was again quite natural. Patient left the hospital next day.

Now this is a curious medical history. It consists, briefly, in "fits," said to have been cured by calomel; repeated hæmoptysis and a cough; diarrhœa for several months; return of alleged hæmoptysis; the colored fluid shown not to have come from the lungs; sudden onset of spastic contractures in limbs; analgesia; sudden disappearance of the same; sudden and temporary interference with the special senses. It involves manifest incongruities which are not to be explained except upon the ground of hysteria. Our observations on this patient whilst in hospital showed that he possessed in a marked degree many of the mental characteristics with which we are especially familiar in women who suffer from this malady, viz., a keen interest in their own medical case—a craving for a corresponding interest on the part of those around them—a readiness to furnish details concerning symptoms—close observation of all treatment and its apparent effects—a proneness to exaggerate or even falsify in order to increase the sympathy they so long for. Further enquiries, too, developed the fact that this man's moral sense had become very obtuse. He had made fraudulent representations to certain persons with reference to financial and other matters, and had succeeded in committing some petty acts of "swindling." A knowledge of this might, perhaps, have been taken as invalidating the case entirely, and caused one to say that we were dealing with no disease at all, but with deliberate simulation only. I did not take this view of the case, and I think that a consideration of the details given will convince any one that a real disease of the nervous system was present. The most important observation bearing out this idea was that pertaining to the curious and rapidly-developed spastic phenomena with associated sensory disturbances, a condition which it would take a *very* clever imposter to evolve out of his inner consciousness. I would note the assistance derived here from microscopical examination of the bloody fluid alleged to have been spat up. Dr. Johnston knew nothing of the case—simply getting the specimen in a numbered vial along with several others from the hospital. He, you will have noticed, repudiated it as a specimen of sputum at all, which fully confirmed suspicions already entertained.

The next case, also in a male, presents very different features:

Case II.—J. W., aged 20, admitted October 10, 1884, with high fever, delirium and cough. He was found to have been ill for thirteen days with symptoms indicative of pneumonia, and physical examination showed the usual signs of consolidation of the apex of the left lung. During the next two days he remained quite ill. Temperature 101° to 103°; pulse 120. Delirious at nights, no sleep, and required constant watching. On the 13th defervescence took place; the morning temperature being 98°, and the pulse 68. The note of this day, however, says: "Will not put out his tongue; refuses to open his mouth for a drink of milk; will not answer any questions." And the remark significantly follows: "Except for this mental condition, is evidently much better." I may merely say that, as regards his affected lung, the process of resolution proceeded rapidly. No further elevation of temperature occurred, and he began to sleep a little at nights. It was on the days subsequent to the 13th that we observed the special symptoms indicative of the nervous disorder. On the 14th, the note describes him as "a little more rational, and willing to speak and to explain his feelings and other symptoms." On the 15th, "had a good sleep last night, is quiet

ıd fairly rational. On the 16th, "has fallen into lethargic condition, which is rapidly deepening,) that he is roused with considerable difficulty. y loud speaking can be made to protrude his ɔngue (which is dry). Lies quite still on his back, ith occasional twitchings of the hands and a oderate talkative delirium. No change in the ıpils. Urine passed in bed." On the 17th, "a ɔod night: bright, asked for his dinner; spoke ıite briskly at the mid-day visit. Soon after elapsed into a soporose, semi-comatose state simar to yesterday. Can only be aroused momenrily with difficulty." On the 18th, "a repetion of the same thing; a good night; a bright renoon, and at 1 p.m. a relapse into an apparently ısensible condition." At this time no shouting, naking or violent pinching succeeded in arousing im, and no answer of any kind could be obtained om him. Late in the afternoon he was again ıite wide-awake. 19th, less stupor and delirium. ɔth, "Eats and sleeps well; quite lively and ıtelligent; no attacks of stupor." From this time is convalescence was uninterrupted.

We learned from the nurse, during the days of is *stupid* attacks, that these might come on and go ff perhaps twice or three times during the course f the day. That the condition varied remarkbly we had sufficient evidence from what we ourelves observed. The most usual condition was ir intelligence in the forenoon, rapidly or even uddenly changing to a state of apparently proɔund lethargy and stupor at about 1 p.m. Another point was that on these days he knew his riends when they came to visit him, but talking ɔ them made him extremely excited, and he cried rofusely - so much so that the nurse was twice bliged to send them away.

To recapitulate the facts of this case: A deliate, slim young man, aged 20, nervous looking, ontracts pneumonia and arrives here at the height of that disease, delirious; typical defervescence ɔccurs, and the case (*quoad* the pneumonia) ollows a normal course towards resolution. But, nstead of our patient presenting the calm aspect ınd cheerful face of the ordinary pneumonic conalescent, we find him continuing to talk incoherently, even in the daytime, lying in a limp fashion ɔn his back with his eyes shut. Next day found n a deep stupor, lying quite still and breathing quickly like one asleep. Then, again, he is found wide-awake and quite chatty. The sight of friends excites him and makes him weep. This condition passes off in a few days, and he is well.

The facts detailed are, I think, sufficient to warrant the diagnosis made—the hysterical condition assuming here the form of lethargy, and having been induced by the debility resulting from the acute disease.

I was recently consulted concerning the son of a gentleman in a neighboring town. The lad, aged 16, having been suffering from toothache and swelled face, became suddenly apparently insensible, remaining so several days and causing much anxiety. He then began to rouse up at intervals and appear rational, going off again in a short time into the same lethargic state. At other times he would talk and sing to himself, paying no attention to what was going on around him, and they feared his mind was giving way. I received full particulars from his medical attendant, and, replying, gave a favorable prognosis, because I looked upen the case as an odd form of hysteria in an adolescent. He was subsequently brought to the city to see me, and from my examination I was still further convinced that this was the true explanation of it. He quite recovered and continues well.

The paralyses of hysteria are always interesting. The diagnosis is often sufficiently obvious, but sometimes it is beset with many difficulties. It is notoriously *the* disorder, of all others, which offers to the charlatan and the faith-cure people the most attractive and the most lucrative field. Some time ago a lady, whom I had previously treated for functional aphonia, began to complain of certain indefinite pelvic symptoms, and finally lost power to a considerable extent in both lower extremities. I advised a stay in the city (she lived some distance away) for the purpose of trying the effect of isolation from sympathizing friends and massage. This was not done, however, and her friends took her instead to New York. Here (perhaps unfortunately) they consulted a very eminent gynæcologist. He pronounced the verdict that it would be necessary to remove the ovaries. This terrified her, her friends refused their consent, and she remained bed ridden and hopeless of any relief. Just then a bright light of the "faith-cure" or "healing by prayer" community happened along. He found, on enquiry, that she had any quantity of "faith," and he was, therefore, able to promise everything. Surely enough, she walked in a couple of days, and after a few weeks returned home satisfied that with her a real miracle had been wrought. Her

feelings of gratitude took the form of a "statement" contained in a small pamphlet headed "modern miracles," which was no doubt widely circulated, and of which I received a copy. Being a very clever lady, her "statement" tells most eloquently of her rapid descent into the confines of the valley of the shadow of death, and of her rescue therefrom by the hand of an angel in the garb of the "faith-cure" man. It might be mentioned, *en passant*, that this ministering angel was not above the sordid meanness of accepting the very handsome fee of $1,000 presented to him by his grateful worshipper. This lady is now quite well and likely to remain so, having subsequently married the man of her choice, whose temporary defection was probably the cause of the entire trouble.

It is quite justifiable to take a leaf out of the book of the "faith-curers." Positive and dogmatic statements go a long way with patients of this kind, and the employment of some visible means perhaps assists in bringing about the desired restoration. This plan was adopted in the following cases with the happiest results :—

Case III.—*Hysterical Hemiplegia.*—T. S., aged 16, servant, admitted to hospital 8th November, 1886, complaining of weakness of left arm and leg, and pain in the left side of head and neck. Three days previous to admission patient began to complain of a dull, aching, continuous pain in the forehead, not worse at any particular time. Had sensation of chilliness and slight attack of epistaxis. Took to bed at once, and next day suffered from weakness in left arm and leg, which gradually became worse until admission. Enjoyed good health until two years ago, when on waking up one morning found her left arm and leg completely paralyzed. These members were tender and painful, and of such severity as to cause her to cry out whenever touched. Sometimes the right arm and leg would become clonically contracted for a few minutes, whilst the left arm and leg would be at rest. Was quite conscious all the time. Facial expression and power of speech were not affected. Patient remained in bed until last Christmas, and at this time made some improvement, so much so that she was able to go about by the aid of crutches, and one month later was quite well. The treatment consisted in the application of liniments to the affected parts. Began to menstruate at 13½ years of age; has always been irregular, intervals between the periods varying from fifteen days to six weeks. Appetite has been good; bowels irregular. Slept well. Patient says she has been subject to fits of laughing and crying.

Upon admission.—Complains of a dull, aching, continuous pain, localized in the forehead; of numbness and weakness of the left arm and leg; and of inability to lie upon the left side. Patient is of small stature; her features are of an Indian type (her father is chief of an Indian tribe and her mother a French-Canadian); is dark-complexioned; wears a heavy, angry expression upon face; face is symmetrical; assumes the dorsal decubitus, but, forgetting herself, turns over to the left lateral. Pupils active and equal. Tongue moist and clean, and protruded in the median line. Power of flexion, extension and abduction of upper arm, extension of forearm and hand grasp of the left side apparently very weak. Whilst conversing with her she forgets the weak condition of the muscles of the upper extremity, and raises her hand to brush her hair back. Flexion and extension in left leg slightly weaker than that of right. Muscles of affected parts are well developed and firm. Tactile sense intact throughout, though analgesia is present to a slight degree in left arm and leg only. Reflexes normal. When walking, patient limps on the left leg, keeping the foot strongly everted, and puts it down to the ground as if afraid of hurting herself.

A faradic current was daily applied to the affected limbs, and she was encouraged to rub them several times every day with a liniment. She was told that this would cure her in a few days. At each visit careful enquiries were made as to the regularity with which she had carried out her treatment. The weakness of the limbs steadily improved, the gait shortly became natural, and she was discharged quite well in a fortnight.

Case IV.—*Hysterical Paraplegia.*—M.H., aged 22, servant brought into the hospital upon a chair, complaining of inability to walk.

History of the case.—Until day previous to admission patient enjoyed good health, when, upon awaking in the morning, she found herself quite unable to move her legs. Later on in the day, with assistance, got out of bed, but her knees suddenly gave away, thus precipitating her to the floor. Returned to bed and remained there until brought to the hospital. Was quite conscious. No perverted sensation. Complained of severe and continuous frontal headache, described by the patient herself as "boring" in character; it is not

worse at any particular time. Upon the morning of admission to the hospital she said her voice had suddenly become weaker, and at times she completely lost it. Also complained of palpitation, with tenderness under the left mamma. Has no vesical or rectal disturbance. Menses are irregular in their appearance, small in amount, and each period is generally preceded by pain.

Examination.—Patient is a healthy-looking and well nourished female; takes a great deal of care to describe fully and dwell at length upon her complaints. The breathing during this time is quite tranquil, but when attention is drawn to the painful spots the respirations immediately become quickened and somewhat sighing in character. Voice is weak: inclined to whispering. Lower extremities are extended and the feet are in a natural position. Skin is warm and moist. Muscles not wasted. Says she cannot move the legs at all. The plantar reflexes, if suddenly tested, causes slight withdrawal of the feet. Tactile sense is normal. Marked analgesia in the lower extremities from the feet to as high as the knees. Pressure over and below the left nipple causes patient to wince, but with the attention misdirected these points are no longer tender. It was now insisted upon that the patient should get up and try to walk, and this she did, but her gait was staggering; the heels were placed firmly upon the ground, the toes extended, and the plantar arches much elevated; her eyes were kept fixed upon the ground, at times she would appear as if about to fall, but this was generally done when she was well within reach of good support. Examination of the larynx by Dr. Major was negative in its result. Heart and lungs negative. Urine 54 ozs.; very pale, acid: specific gravity 1015: no sugar, no albumen. Four days later the analgesia had entirely disappeared, the painful spots no longer present, and the voice quite natural, but her gait had changed. Now patient's walk may be described as follows: Walks on the ball of the great toe of right foot, the heel is raised from the ground, the left foot is placed in advance of the right, and whilst resting upon it, the right knee-joint suddenly gives away; but patient soon regains the upright position and continues to walk as before. She was given some bread pills, had electricity applied, and used a stimulating liniment. In about two weeks the gait was quite natural, and all pains and aches had disappeared. The patient was now discharged from the hospital.

The same precaution was taken here to impress this patient from the outset with the idea that her case was quite curable; that she would soon regain the power of her limbs; and to insist upon her following certain prescribed directions very carefully.

Case V—*Hysterical Vomiting.*—H. S., aged 27, servant, admitted, complaining of vomiting and of pains in the abdomen, legs and head.

Previous history.—Enjoyed good health until six months ago, when one morning, whilst lying down, patient was suddenly seized with a sharp pain in the left lower axillary region, extending throughout the body, aggravated by deep inspiration and coughing. Vomiting set in, and for the first time. The attacks were aggravated by ingestion of food, but would also occur independently of any food taken. There was no dysphagia. The food was rejected about an hour after it was taken. The ejecta consisted of what was eaten. Even fluids could not be retained. Never had hæmatemesis. No pain after eating. Had no desire for food. Suffered from insomnia. From these attacks of vomiting, which have continued ever since in a greater or lesser degree, patient has lost much in weight and strength. About this time patient began to suffer from what she calls fits, described as follows: The aura consisted of a sense of fullness in both ears, and accompanied with a loss of hearing. This would last about half a minute, then patient would become unconscious and fall down anywhere, on one occasion cutting left eye, and, again on another occasion, whilst in one of these fits, received a black eye. These fits are not attended with any tonic or clonic contractions of any of the muscles of the body. No frothing at the mouth. Has never bitten the tongue whilst in one of these fits. The duration of a fit is from a few minutes to one or even two hours. Has had as many as two fits in one week. Says that cold water, if thrown upon her face, always brought her to her senses.

Patient is a married woman and the mother of four children, all enjoying good health except the eldest, a boy aged 8 years, who is subject to fits such as his mother suffers from.

Family history.—Mother and four sisters died of consumption. One brother, at 13 years of age, had fits similar to those patient suffers from for fifteen years, and died from their effects.

Present history.—At present patient complains of vomiting, of pains in abdomen, legs and head,

and of fits. The attacks of vomiting consist in almost everything being ejected from the stomach within half an hour to an hour after the ingestion of food. The ejecta, upon examination, are found to amount to half a pint at any one time of clear, transparent mucus fluid, acid in reaction; the microscope reveals detritus of food; no blood corpuscles; no sarcinæ. Suffers no pain after the ingestion of food; no dysphagia. Complains of anorexia, constipation and insomnia. The pains in abdomen, legs and head are very indefinitely located in these regions, their site being very changeable, and their character altered from time to time—at one moment being dull aching, and the next minute sharp and shooting. Patient says she is kept awake by these pains, and they are much increased by movement and examination. The only relief to the vomiting and pains was the frequent use of morphia.

Examination.—Patient is of average height, anæmic-looking, not well nourished; muscles soft and wasted; skin warm and moist; assumes the dorsal decubitus; evidences of recent injury to left eye, no scar seen. Patient is very restless; keeps turning her head from side to side; rubs abdomen with the right hand; respirations all this time becoming quickened, shallower and sobbing in character. This having apparently reached a climax at the end of one minute, the patient begins to cry, stops rubbing the abdomen, and turns to the right side, all this time apparently suffering very severe pain. Shortly after this the patient sat up in bed, eructated a large quantity of gas, and vomited about half a pint of thin, clear, watery-looking fluid. She now lay down in bed apparently exhausted, the respirations being rapid and sobbing in character. Pulse 80, full and regular. Respirations 36. Temperature 97°. Tongue moist and covered with slight fur in centre. Abdomen full, not distended; tenderness, amounting to hyperæsthesia, generally distributed, but more marked in right and left iliac and epigastric regions. This hyperæsthesia disappears entirely when patient's attention is elsewhere directed. No tumor made out. Liver and spleen normal. Nothing unusual in the position of the extremities. Muscular power is good. Gait natural. Tactile sense everywhere present. Analgæsia is limited to the left leg from the ankle to knee-joint. Reflexes slightly exaggerated. Heart and lungs normal. Urine 58 ozs., pale in color, acid; specific gravity 1012; no albumen, no sugar.

For the next forty-eight hours the attacks of vomiting were incessant during the day-time, but always ceased at night. Patient ejected all food taken during the day, but at night the food left at the bedside partially disappeared.

The evening after admission patient had one of her usual fits, and it is described as follows: Is quite conscious and answers all questions quite correctly. The respirations are rapid (38 per minute), shallow and sobbing. The arms are extended and the fingers firmly closed, both arms shaking as if patient had a chill. The lower extremities are natural in position. No disturbed sensibility. This condition lasted for about two minutes, and then patient assumed a quiet state. Pulse during fit was 72, full and regular. From this day until exit (6th December) patient had no return of the attacks of vomiting nor of the fits, and she improved very much, the appetite returning, sleeping well, and the bowels regular. The treatment consisted in giving her a placebo—viz., peppermint water.

Society Proceedings.

MEDICO-CHIRURGICAL SOCIETY OF MONTREAL.

Stated Meeting, March 25th, 1887.

J. C. CAMERON, M.D., PRESIDENT, IN THE CHAIR.

Culture of Tubercle Bacillus.—Dr. JOHNSTON called the attention of the Society to a new method of cultivating the bacillus of tubercle, and exhibited several cultures.

Extirpation of the Kidney.—Dr. WM. GARDNER exhibited a kidney removed by lumbar incision. The patient, aged 56, of intemperate habits, had been complaining since 4th Dec. last (three and a half months), when she took suddenly ill with rigors, fever and pain in right lumbar region. The symptoms were acute and severe—severe rigors, profuse sweating, severe pain, frequent vomiting, and continued so till the operation. The urine contained pus at intervals, and micturition was frequent and painful. The patient was very fat. On examination, a diffuse, very tender, ill-defined swelling in the right lumbar and hypochondriac region. No fluctuation. On percussion over the swelling, intestinal note. Exploratory abdominal incision over the swelling. Parietes enormously thick. Omentum extremely fat. By palpation the tumor was now ascertained with tolerable cer-

tainty to be the kidney. The abdominal incision was closed, and the kidney, containing half a pint of pus, was removed by the lumbar incision. No calculus or any other cause for the suppuration could be found. The patient was watched in hospital for two days before the operation, when the secretion of urine was almost *nil*. For the first twenty-four hours 40 ounces were secreted and passed naturally; for the next twenty-four hours none at all. On the third day she was distinctly soporose. A small quantity of urine passed in bed. The same on the fourth day after the operation, the day she died. Just before death four ounces was drawn off by the catheter. No autopsy allowed.

Discussion.—Dr. JOHNSTON said the kidney seemed to show a condition of chronic hydronephrosis, accompanied by an acute nephritis. The collection of pus did not appear of long standing; there was no pyogenic membrane.

Dr. SHEPHERD could not quite agree with Dr. Gardner's treatment of this case. Nephrotomy seemed to be called for in this case,not nephrectomy He did not think a nephrectomy should ever be performed without a previous nephrotomy, as no seriously diseased kidney could be shelled out readily. The history seemed to point to pyonephrosis, and the large amount of urine passed after the operation might be due to a collection outside. the injured kidney.

Dr. TRENHOLME referred to a similar case occurring in his practice. There was a cyst in the neighborhood of the kidney, which he tapped and drew off about two quarts of fluid. Patient's symptoms were greatly relieved, but the cyst returned, and on again tapping three pints were obtained. The patient gradually got worse, however, and the post-mortem examination showed an obstruction of a valvular nature in the ureter, near the hilum of the kidney.

Dr. GARDNER, in reply, stated that the case was not an easy one to diagnose, as the panniculus adiposis was so thick the nature and situation of the tumor could not be satisfactorily made out. The patient was desperately ill, and the operation was undertaken as a last resource.

Extirpation of the Uterus.—DR. GARDNER exhibited a uterus he had removed a week before. The patient was 47 to 50 years old. Menses ceased two years before; occasional hemorrhages continued. No serious pain, but a constant discharge. The case was then regarded as one of sarcoma. The operation was easy. Dr. Johnston concluded, however, that it was carcinoma. The tumor was in the form of series of outgrowths in the cavity of the uterus.

DR. TRENHOLME congratulated Dr. Gardner on the success of his operation, and said with regard to extirpation of the uterus for malignant disease, that while he had performed the operation some seven or eight times with much immediate success yet in *all* cases the disease rapidly returned. He now no longer regarded the operation with any favor.

Laparotomy.—DR. TRENHOLME exhibited a cyst, about the size of an egg, removed from a patient 19 years of age, confined of her first child eleven months ago, since which time she has been ill. Previous to her accouchement she had enjoyed good health, but was attacked with a severe pelvic arthritis and peritonitis three days after she was delivered of her child. Her present state is one of constant suffering, with pains in body and general nervous and gastric derangement. Temperature varies from 99° to 101° and 102°; pulse from 100 to 140. Lips and teeth exhibit usual feverish conditions. On examination, find a tumor level with Poupart's ligament filling a good part of pelvis on right side. Tumor was dense and strongly adherent to wall of pelvis; not perceptibly moveable, and somewhat nodular.

Operation.—On opening cavity of abdomen, the mass was found to coalesce with surrounding structures, and at no point was it at all possible to separate the mass. The specimen shown to-night was situated between the bladder and the uterus. As operation could not be completed, the abdominal wound was closed. The patient bore the operation well, but on the fourth day a profuse and fœtid flow began to escape from the abdominal wound, and as the state of pulse, high temperature, etc., gave little hope for continuance of life, the patient returned to her home in the townships. She bore the journey (120 miles) well, and at the end of two weeks was rather better than when she left the city.

Dr. Trenholme remarked that this was the fourth serious case of abdominal section he had had in succession, all of whom, he was glad to say, had so far recovered. One was a solid cyst of left ovary (8 lbs.); one a suppurating cyst of left ovary (12 lbs.); one a dermoid cyst (4 lbs.), and the present case.

Case of Nephro-lithotomy.—Dr. SHEPHERD related the case. He said:—

The following case is of interest, not only on account of the large size of the stone removed, but also because the question of the comparative merits of nephrotomy and nephrectomy is raised in such conditions of the kidney as existed in this case. The patient was sent to me by Dr. J. R. Johnston of Spring Valley, Minnesota, with a letter stating he suspected the man was suffering from stone in the kidney. The history of the case and condition on entrance I quote from the Hospital Report:

"W. C., aged 26, was admitted into the Montreal General Hospital on the 18th of October, 1886, with a history of long-continued pain in the left lumbar region and pus in the urine.

"*History.*—Family and personal history good. Seven years ago he first noticed that small quantities of blood were passed in the urine at the end of micturition; four years ago, blood was mixed with the urine, giving it a smoky appearance. Has seen no blood in the urine for two years. During the last seven years he has been troubled with continuous pain, not always very severe, in the left loin, occasionally radiating downward to the crest of the ilium. He occasionally has periods of very severe pain lasting for some two or three weeks, after which he is comparatively well; of late years these periods of pain have not been so frequent, and when they do occur the pain is of a sickening character, and causes morning vomiting. Sudden movement, as sneezing and coughing, brings on an attack of pain. Five years ago first noticed a whitish deposit in urine; up to a few months ago this was quite small in amount, and was passed with the morning urine. No history of renal colic.

"*Present condition.*—Is a fairly well nourished young man, of medium size, and with an anxious expression of countenance; complains of dull, aching pain in left lumbar region, and immediately below the last rib, in the axillary line, is a very tender spot the size of a twenty-five cent piece. He says the pain radiates from this point. Urine has a specific gravity of 1015, and contains 15–25 per cent. of pus. Some days there is only a trace of pus. At other times there is as much as 25 per cent. Urea, 7½ grains to an ounce. Amount of urine daily excreted, 40–50 ounces.

"By external examination no tumor or fulness can be detected on the left side."

On the 28th of October he was put under ether, and the abdomen thoroughly examined by both Dr. George Ross and myself, but no tumor could be made out. The left loin was carefully explored with the long needle of an aspirator, but failed to reach either pus or a calculus. It was concluded, from the history of the case and the symptoms, that a stone probably existed in the pelvis of the left kidney; so, after consultation with my colleagues, I decided to cut down on the left kidney by lumbar incision, and explore it.

Operation.—October 30th, the patient, being under ether, was placed on his right side, with a hard pillow under the right lumbar region, and a horizontal incision was made close below the last rib of the left side, commencing at the edge of the erector spinæ muscles, and extending downward and forward for some five to six inches. After dividing the muscles of the abdomen, the quadratus lumborum was reached, the lumbar fascia divided, and the kidney searched for; the lower end was felt at a considerable depth, in fact, it could be barely reached with the fore and middle fingers of the right hand, so the opening in the loin was enlarged by an incision at right angles to the first, making the wound a crucial one. A long needle was introduced into the kidney, and a calculus was immediately felt. The kidney being steadied by pressure from without, I made an incision down to the stone in the long axis of the organ, of some three inches. Through this incision an immense stone could be felt with the finger, but owing to its great fixity and large size it could not be dislodged. Whilst endeavoring to remove the stone, I accidentally ruptured a large artery, which ran to the lower end of the kidney, and was, no doubt, a supernumerary renal; the hemorrhage was profuse, and I immediately introduced one hand into the wound, and so prevented further bleeding, while with the other I managed to catch the bleeding vessel with a pair of long artery forceps. The stone proved too large to be grasped by a lithotrite, and too hard to be broken by a cutting forceps. I attempted to break it with a chisel and mallet, but failed, because of the difficulty of getting fixation of the kidney. The incision in the kidney was now further enlarged, and the stone gradually separated from the kidney tissue with the finger; even now, owing to the prolongations into the calices, the stone could not be removed. With considerable difficulty I managed to free the lower end of the stone, which blocked the entrance of the ureter, and lifting it up, requested Dr. James Bell to grasp it with a pair of large lithotomy forceps;

this was done, and the stone was brought away after the expenditure of considerable force. On examining the removed stone, it was seen that there were a couple of projections on it, one of which appeared to have been freshly broken off; so the hand was again introduced into the wound and a large fragment removed from a calyx; other smaller pieces were also removed. As the patient had been already an hour on the table, and was becoming weak from shock and loss of blood, no further exploration took place.

During the operation not a single drop of pus was seen; none apparently surrounded the stone, which was quite closely embraced by the surrounding kidney substance. So far as naked eye appearances went, the part of the kidney seen was perfectly healthy. At one time, I thought it would be necessary to remove the kidney, as it seemed impossible to remove the stone without it, but the very healthy appearance of the portion of the organ seen (the lower end), and the absence of pus, determined me to persevere, and, if possible, remove the stone and leave the kidney till the condition of the other could be ascertained. At no time during the operation could the kidney be brought to the surface, and the operation had to be performed by feeling more than sight.

After washing out the wound thoroughly with a 1 : 2000 solution of corrosive sublimate, and introducing a large drainage tube, the wound was brought together with silk sutures, and dressed with sublimate jute pads. At the close of the operation the patient was in a fairly good condi tion, and did not show much evidence of shock; and, although he had lost a considerable amount of blood, his pulse was full and strong, and not more than 80. The weight of the removed stone and fragments immediately after the operation was 4 oz., 7 drachms. It measured 3½ inches in length, and 9 inches in circumference, and consisted entirely of triple phosphate.

After the operation, which took place at 2 p.m., the patient did not pass any urine till noon next day, when he voided 7½ oz. As there had been a great deal of oozing, the wound was dressed next day. Temperature, 101 °. Pulse, 120. He still had vomiting from the ether.

Nov. 1. He passed 32 oz. of urine which was free from pus and blood.

For some time the patient progressed slowly toward recovery; his temperature ranged between 98 ° and 100 °, and the amount of urine from 25 oz. to 50 oz. daily. The wound, which was not very sweet, and from which came large quantities of urine, gradually healed, and the tube was removed in the early part of December. He now began to have high and irregular temperature, with some sweating; from the 10th to the 25th of December his temperature ranged from 98 ° to 102 °, and for several days after reached, in the afternoon, as high as 104 °-105 °. Fearing that some collection of pus was forming about the kidney, I reopened the wound, introduced my fingers, and explored the pelvis of the kidney, but without result, except that a few flakes of calcareous matter were brought away. It was now decided to cut down and remove the kidney, but the patient quite unexpectedly took a turn for the better, and improved so much that, in the early part of January, he was able to go about the ward, enjoy his meals, and gain flesh. The sinus in his right loin never healed, but continued to discharge large quantities of urine with a small amount of pus. At this time my service at the hospital having expired, I only saw my patient occasionally. His temperature was for several days quite normal, and then for a time would range as high as 101 °. The amount of urine varied from 30 oz. to 40 oz. daily. I saw him early in February, going about, and apparently in fair condition. On the 10th of February he suddenly became jaundiced, his temperature rose to 102 °, and he had severe sweatings. I saw him, and examined his side carefully, but could discover no evidence of any collection of pus about the wound, and the amount of urine reached 40 oz. daily. The fistulous opening in his side discharged urine freely, and a very small amount of pus stained the dressings. He gradually became worse, and died comatose on the 14th of February, three and half months ofter the operation.

The autopsy was performed by Dr. Wyatt Johnston, pathologist to the hospital, and the following is taken from his report: "Body jaundiced. In left lumbar region, a depressed cicatrix, about two inches long, is seen with a sinus toward the centre, from which fetid pus can be squeezed out. On opening the abdomen, a large oval mass is seen in left lumbar and extending up into the left hypochondriac region. This mass has a quantity of fibrous exudation surrounding it, and is very difficult to remove, being firmly attached to the lumbar muscles, spleen, and vault of the diaphragm. The retro-peritoneal glands are acutely

swollen, but show no signs of suppuration. The aorta and vena cava are not directly involved in the mass, and can be readily dissected off. Near the inferior extremity of kidney, two inches above the crest of the ilium, a small artery, one and a half inches long, running directly from aorta to kidney, is seen; it is obliterated, apparently from a ligature. The fatty capsule of the kidney is densely infiltrated with fibrous tissue, and cannot be removed without tearing the kidney substance; the left kidney itself is greatly enlarged, and forms a fluctuating mass weighing nearly 1,000 grammes. On opening the pelvis, a little fetid pus escapes, and the sinus in the loin is seen to open into it. On palpation a small calculus mass can be felt towards the cortex in one of the calices of the kidney; the calculus is the size of a hazelnut, and appears to be broken off in one spot. It is enclosed in a small pocket of pus. The ureter immediately below the pelvis of the kidney is completely obstructed, and its walls are much thickened. On incising the kidney along its convexity, it is found to consist in the upper portion of a series of large communicating sacs containing over ten ounces of fetid pus. These cavities do not communicate with the sinus or the pelvis of the kidney, but are completely shut off from the rest of the kidney by thick, fibrous walls, showing that the disease is of long standing. Within these sacs lie five or six irregular branched calculi, varying in size from a bean to a walnut. The lower fourth of the kidney contains a considerable quantity of healthy renal structure. Bladder and lower part of ureter normal. Right kidney double normal size, and looks to be perfectly healthy. Liver shows numerous enlarged lymph glands lying beside the bile ducts, but bile can be easily expressed. Other organs healthy."

There is not the slightest doubt that this patient died of septicæmia, due to the fetid abscesses in the upper end of the kidney. These could not be diagnosticated by external manipulation, and from the fact that the part of the kidney seen at the operation was healthy in appearance and contained no pus, the condition of its upper end was not suspected. So far as the operation itself went, it was successful, but one lesson may be learned from this case, viz., that with a large stone in the pelvis, it is almost impossible to have a kidney which has not undergone grave changes, and its thorough exploration by incision is indicated. Had there been pus around the stone and the kidney tissue not looked so healthy, I should have attempted to remove the kidney, but I had in my mind a specimen in the Museum of the Medical Faculty of McGill University, where the pelvis of each kidney, in a man, is filled by an enormous stone, while the surrounding kidney structure is comparatively healthy, and where there was not a drop of pus or the sign of disorganization. In my case, however, although in the immediate neighborhood of the large calculus the kidney was healthy, stones unconnected with that in the pelvis. The kidney was placed so deeply and situated so high up that, with even the very extensive lumbar incision which was made, it could not be properly explored, and I very much doubt if it could have been successfully removed by the loin. Its removal, owing to the numerous adhesions to important organs and its location, would have been a matter of serious difficulty, if not an impossibility, even by abdominal incision for at the autopsy by the combined abdominal and lumbar incision it was only by cutting freely the surrounding parts that its excision was accomplished.

In such a case incising the kidney in every part, evacuating the pus, and removing the calculi would be the proper procedure. Diseased kidneys which enlarge downward are much easier to remove by lumbar, and also abdominal incision, than those which enlarge upward, and are wholly under cover of the ribs.

There is another point about this case which is worthy of notice, and it is this: When a kidney is highly placed it may be enlarged so as to form a considerably sized tumor, which cannot be detected by the most careful palpation, even when the patient is placed under ether. The failure to find the stone by needle exploration, before the operation, was due to the same cause—the high position of the tumor and its great depth.

In connection with this case I might mention one reported by Prof. Guyon, of Paris, which is very similar to the one narrated above. In Guyon's case, however, a distinct tumor could be felt externally. After cutting down on the tumor and incising it he found the pelvis of the kidney completely filled by an enormous stone, with processes extending into the calices, these processes were cut off with forceps, and the large calculus extracted with difficulty; after the removal of the smaller pieces, the pelvis of the kidney was explored with the finger and sound, and no more

stones could be felt. The patient died some two weeks after from hæmoptysis, and at the autopsy it was found that the kidney was so adherent to the surrounding parts that it probably could not have been extirpated. Several more stones were found in the upper end of the kidney in cavities separated from the pelvis by connective tissue. Prof. Guyon, in the course of his remarks on this case, states that here nephrotomy was preferable to nephrectomy, and that had the kidney been properly incised the other stones would have been found, that in such cases the kidney should be freely incised and every nook and cranny explored; he holds that if this were done in cases of calculous pyelitis nephrectomy would never be called for.

Formerly it was feared that free incision of the kidney would cause severe and dangerous hemorrhages, but experience has taught surgeons that the danger is an imaginary one, and that kidneys which are much disorganized may be incised without fear of bleeding, and that even in healthy kidneys the hemorrhage from incisions is easily and permanently controlled by pressure.

In such cases as the one above narrated, where the stone is of great size and the kidney is enlarged, the mere extraction of the stone in the pelvis should not satisfy the operator; he should thoroughly examine the kidney in every part by free incisions so as to be sure no calculus is left behind. External manipulation of the kidney is not sufficient to detect stone, and in such cases as my own, even exploration through the kidney pelvis would fail, without further incision, to detect calculi unconnected with that in the pelvis.

Up to a short time ago the largest stone removed by lumbar incision was under two ounces in weight. Lauenstein reports a successful case of removal of a large calculus (weighing 25 grammes and composed of the triple phosphates) from the pelvis of the kidney. He had to break the stone with a lithotrite before he could extract it. In his paper he states that it was the largest stone removed up to that time, though not the heaviest. Three months after the operation, the sinus in the loin had completely healed, and when the article was written the patient was perfectly well.

Dr. John Neill, after relating a case of large renal calculus found after death, quotes from *Cyclop. Pract. Med.* the following case: "A remarkable instance of such calculus occurred in the person of a natural daughter of Sir Richard Steele. No nephritic symptoms took place until shortly before death, when severe pain was left in the region of the right kidney, fever followed and speedily proved fatal. A calculus of oxalate of lime weighing 7½ ounces was found in the right kidney, which was so thin by absorption as to be reduced to a mere membrane. In this instance the stone could be felt, during life, through the loins, inducing a belief that the kidney had become ossified (Catal. Museum of Royal Coll. Surg., London. Note by John Hunter)." In this case there was evidently but little suppuration, or the stone could not have been so easily recognized.

Mr. Victor Horsley, on Sept. 16, 1885, removed a stone weighing 2¼ ounces from the pelvis of the kidney of a middle-aged woman; ten days after she was doing well. It was the largest stone removed from the kidney up to that time.

Mr. W. L. Brown reported a case before the Birmingham and Midland Counties Branch of the British Medical Association, in May last, where he had removed from the kidney by abdominal section a stone weighing 11 ounces. The kidney tumor occupied the right half of the abdomen and contained three pints of pus. The cut edges of the cyst were stitched to the abdominal walls and the cavity drained. The patient died suddenly eleven days after the operation from heart clot. So far as I know, the stone in my case is the largest ever removed by lumbar incision.

Discussion.—Dr. Bell said that he had watched this case with great interest for some time, and considered the question of the best method of dealing with such cases a very difficult one. It would be impossible to drain so many pus cavities even if all the outlying calculi could be removed. Excision of the whole kidney would, perhaps, have given better results, though such an operation was scarcely indicated at the time.

Dr. Johnston said that the post-mortem showed that it would only have been possible to remove the kidney by resecting two or three ribs, so firmly attached was the mass about the kidney.

Stated Meeting, April 15th, 1887.

T. J. Alloway, M.D., 2nd Vice-President in the Chair.

Yeast Saccharometer.—Dr. Reed showed a neat and useful little piece of apparatus called the Emhorn's Yeast Saccharometer, for qualitative and quantitative estimation of glucose in urine.

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Aloin et Strychnine, Med. prop.—Tonic Laxative. Dose, 1 to 2.	60	2 75
Aloin et Strych. et Bellad. Med. prop.—Tonic, Laxative. Dose, 1 to 2. Aloin, 1-5 gr. Strychnine, 1-60 gr. Ext. Belladon. ⅛ gr.	60	2 75
Atropine, 1-100 gr. Med. prop.—Anodyne. Dose, 1 to 2.	75	3 50
Atropinæ Sulph., 1-60 gr. Med. prop.—Anodyne. Dose, 1 to 2.	75	3 50
Caulophyllin, 1-10 gr. Med. prop.—Emmenagogue. Dose, 1 to 4.	40	1 75
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Corrosive Sublimate, 1-12, 1-20, 1-40 and 1-100 gr. Med. prop.—Mercurial Alterative. Dose, 1 to 2.	40	1 75
Digitalin, 1-60 gr. Med. prop.—Arterial Sedative. Dose, 1 to 2.	75	3 50
Elaterium, (Clutterbuck's) 1-10 gr Med. prop.—Diuretic, Hydragogue Cathartic. Dose, 1 to 2.	95	4 50
Ext. Belladonna, (English), ¼ gr. Med. prop.—Anodyne. Dose, 1 to 2.	40	1 75
Ext. Ignatia Amara, ¼ gr. Med. prop.—Nerve Sedative. Dose, 1 to 2.	50	2 25
Ext. Cannabis Indica, ¼ gr. Med. prop.—Anodyne. Dose, 1 to 4.	60	2 75
Ext. Hyoscyam. (English), ¼ gr. Med. prop.—Nerve Stimulant. Dose, 1 to 3.	40	1 75

GRANULES	BOTTLE. 100	500
Ext. Nuc. Vomicæ, ¼ and ½ gr. Med. prop.—Nerve Stimulant. Dose, 1 to 3.	40	1 75
Gelsemin, ¼ gr. Med. prop.—Emetic, Diuretic, Cathartic. Dose, 1 to 2.	75	3 50
Hyoscyamia, 1-100 gr. (Crystals Pure Alkaloid.) Med. prop.—Anodyne, Soporific.	3 00	14 75
Leptandrin, ¼ gr. Med. prop.—Cathartic. Dose, 1 to 4.	40	1 75
Mercury Prot. Iodid., ¼ gr. Med. prop.—Alterative. Dose, 1 to 4.	40	1 75
Mercury Prot. Iodid., ½ gr. Med. prop.—Alterative. Dose, 1 to 2.	50	2 25
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Mercury Iodide Red., 1-16 gr. Med. prop.—Alterative. Dose, 1 to 3.	40	1 75
Morphinæ Sulph., 1-20 gr. Med. prop.—Anodyne.	40	1 75
Morphinæ Sulph., 1-10 gr. Med. prop.—Anodyne. Dose, 1 to 2.	50	2 25
Morphinæ Sulph., 1-8 gr. Med. prop.—Anodyne. Dose, 1 to 2.	60	2 75
Morphinæ Sulph., ¼ gr. Med. prop.—Anodyne. Dose, 1 to 2.	90	4 25
Podophyllin, 1-10 gr. Med. prop.—Cathartic. Dose, 1 to 4.	40	1 75
Podophyllin Comp., Med. prop.—Cathartic and Tonic. Dose, 1 to 2. Podophyllin, ½ gr. Ext. Hyoscyami, ⅛ gr. Ext. Nuc. Vomicæ, 1-16 gr.	75	3 50
Strychnine, 1-16, 1-20, 1-30, 1-32, 1-40 and 1-60 gr. Med. prop.—Nerve Stimulant, Tonic. Dose, 1 to 3.	40	1 75
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Aperient, (Dr. Fordyce Barker).. Med. prop.—Aperient. Dose, 1 to 2. Ext. Coloc. Co. 1⅓ grs. Ext. Nuc. Vom. ½ gr. Ext. Hyoscyam. 1¼ grs. Pulv. Ipecac, 1-12 gr. Pulv. Aloes Soc. 5-12 gr. Res. Podophylli. 1-12 gr.	1 00	4 75
Cascara Comp...... Med. prop.—Laxative, Cathartic. Dose, 2 to 4. Ext. Casaara Sagrad. 3 grs. Res. Podophylli, ⅛ gr.	75	3 50
Chalybeate, 3 grs..... Med. prop.—Anticblorotic. Dose, 1 to 5. Ferri Sulph. 1½ grs. Potassa Carb. 1½ grs.	60	2 75
Cholagogue, (Dr. Blackwood) ... Med. prop.—An admirable Cholagogue Dose, 1 to 5. Cinchonid. Sulph. ½ gr. Euonymin, ½ gr. Leptandrin, ½ gr. Iridin, ½ gr. Juglandin, ½ gr. Podophyllin, ⅙ gr. Ext. Belladon. ⅙ gr. Ext. Nuc. Vom. ⅙ gr. Ext. Hyoscyam. ⅙ gr.	1 00	4 75
Cinchonidiæ Comp. (Warner & Co.) Med. prop —Tonic, Antiperiodic. Dose, 1 to 2. Cinchonid. Sulph. 2 grs. Ac. Salicylic, 1 gr. Pv. Opii, ½ gr. Ol. Res. Capsici, ¼ gr.	1 50	7 25
Cathartic Comp., Cholagogue..... Med. prop.—Cathartic. Dose, 1 to 2. Res. Podophylli, ½ gr. Pil. Hydrarg. ¼ gr. Ext. Hyoscyami, ⅛ gr. Ext. Nuc. Vom. 1-16 gr. Ol. Res. Capsici, ⅛ gtt.	60	2 75
Ergotine Comp. (Dr. Reeves)..... Med. prop.—Sedative, Parturient. Dose, 1. Ergotine, 3 grs. Ext. Cannab. Ind. ¼ gr. Ext. Belladon. ¼ gr.	1 75	8 50

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Dr. RUTTAN referred to the recent introduction of alphanaphthol and thymol as tests for the presence of sugar. These, if reliable, were far too delicate for clinical purposes, as the sugar normally present in the urine can be shown when the latter is diluted one to two-hundred. He also referred to the periodic absence of excess of glucose in diabetic cases, when under proper diet, and stated that proportion of acetone and aceto-acetic acid is usually increased during these intervals. The iodoform test for acetone was probably the best, but required to be carefully made. Nitro-prussiate of sodium and sulphuric acid gives a fine rose-color with urine containing acetone. This reaction, however, has not been shown to be peculiar to acetone.

Unusual cases of Hysteria.—Dr. GEORGE ROSS then read a paper on some unusual cases of hysteria, which appears in full in the present number of this JOURNAL.

Discussion.—Dr. STEWART said the first two cases described by Dr. Ross were interesting and very peculiar. While it may be wise, in acute symptoms in young persons to give positively a favorable prognosis, there is no doubt many cases of paralysis of hysterical origin are perfectly incurable.

Dr. SHEPHERD referred to the case of a young student who had hysterical vomiting, lasting for months, and resisting all treatment. He was so reduced in flesh that the tranverse duodenum could easily be felt through the abdominal walls. He was sent home, there got better at once, and returned well and fat. He believed in a positive statement of cure in cases of hysteria, and referred to a case of hysterical spine of long standing that had been cured by the faith cure.

Dr. WILKINS felt convinced that one cannot be too dogmatic and positive in promises of cure in hysterical casse. He referred to a recent case in hospital of hysterical contraction of the muscles of one arm. The case was at first very puzzling, but when hysterical symptoms were made out, a certain cure was promised, and the patient put under ether, and on recovering from the effects of the anæsthetic was completely cured. The mystery of what was done to them while under ether often effects a cure.

Dr. REED said that real affections of the joints may occur with hysterical symptoms in the same patient. He referred to a case in the General Hospital where hysteria was diagnosed, and yet there was a real affection of the knee-joint.

Dr. GEO. ROSS, in reply, said that it was very difficult, in chronic cases, to make a positive prediction. Charcot states that there are actual changes in the cord in many hysterical cases of a chronic character.

Stated Meeting, April 29th, 1887.

Dr. TRENHOLME, IN THE CHAIR.

Monobrachial Chorea, not post-Hemiplegic.—

Dr. WOOD exhibited a case of monobrachial chorea, not post-hemiplegic, in a boy 15 years of age. Had variola in the winter of 1885-86. Discharged from hospital in January, 1886, with ulceration of right cornea ; otherwise well. The attack of chorea began in March, two months after discharge, and has continued since. He never had paralysis, rheumatism, or any cardiac trouble, and now his general health is good. When asleep the choreiform movements cease, and he exercises a certain amount of control over them at will. Only when he attempts to co-ordinate his arm and hand muscles is the chorea very apparent. He cannot use his knife or fork at table, but can chop wood, move furniture, and do similar work. Pressure over the median nerve near the elbow controls the movements. He had been attending the public school, where the hours extend from eight o'clock in the morning until five in the afternoon. He was kept at home during the past two months, and he has decidedly improved. Weir Mitchell says that cases of localized or limited chorea are not the result of embolism, but are generally due to acquired habits, and he calls such cases "habit chorea." Dr. Wood did not see how his case could be so classed.

Discussion.—DR. BULLER said this case was particularly interesting in view of the recent theories regarding the influence of eye lesions in producing general nervous affections. One physiologist claims that most nervous affections are traceable to ocular affections. The irritation of the ciliary nerve produced by a shrunken eye-ball has caused general epilepsy. Again, chorea has been traced to weakness of the ocular muscles ; difficulty of co-ordination of the eye muscles is productive of many nervous affections more or less severe. It is a common cause of nervous headache. Applying these general principles to the case exhibited, Dr. Buller called attention to the condi-

tion of the eye on the affected side; the patient was quite blind, the eye was shrunken, and there was infiltration of the cornea, though not excessively painful to the touch. He concluded that there was at least a possibility that this peculiar chorea was due to the irritation of the shrunken eye-ball. He suggested enucleation of the useless eye as a possible means of cure. The fact that the boy's condition improved after removal from school might be due to the relief thus afforded to the ciliary muscles.

Dr. Trenholme referred to the use of arsenic in the treatment of chorea. As usually administered (three to five minim doses) he did not think it was of much remedial value, but he had obtained good results by gradually giving a large quantity. He made a practice of beginning with three minims of Fowler's solution three times a day after meals, increasing this to five minims, and continuing the administration till the toxic effects were visible, then discontinue for a time. He usually preceded each meal with a dose of saccharated carbonate of iron.

Pathological Specimens.—Dr. Johnston exhibited some interesting specimens from a case of chronic hydronephrosis. The case occurred in the practice of Dr. R.L. MacDonnell. Dr. Johnston was unable to give the history of the case.

Progress of Science.

CHRONIC CATARRHAL GASTRITIS.

A Clinical Lecture Delivered at the Hospital of the University of Pennsylvania.

BY WILLIAM PEPPER, M.D., LL.D.,

Professor of the Theory and Practice of Medicine, and of Clinical Medicine, in the University of Pennsylvania.

Gentlemen:—I shall ask your attention to a case recently admitted into the hospital, in which there is some obscurity in the diagnosis. The patient, R. F., age thirty years, a clerk by occupation. The family history is good. He is one of twelve children, 10 of whom are living, and all are in good health with the exception of himself. He had the ordinary diseases of childhood, including the scarlet fever. In 1880, at the age of twenty-four, he had a spell of constipation, followed by pain in the bowels, which was severe enough to double him up. This was attended with high fever, and his physician told him that he had inflammation of the bowels, due to a large collection of fæces. The attack lasted one week, and since then his digestion has been feeble. It seems extremely probable that the diagnosis made at that time was correct. The man may have had an attack of perityphlitis from impaction of the cæcum, a very common occurrence, indeed, and this would explain the symptoms which he has mentioned. In this affection there is fever; the decubitus of the patient is dorsal, with the thighs flexed, so as to relax the abnormal walls. Whatever may have been the nature of this attack, however, it was noticed that after it the digestion became impaired; then he began to have a feeling of weight in the pit of the stomach, and regurgitated a clear, watery fluid. This has continued, and other symptoms have been associated with it. For the last three years he has vomited frequently, sometimes immediately after eating and sometimes not for three or four hours after taking food. On the whole, the vomiting has been more frequent in the evening, and he then rejects partially digested food which he has taken during the day. There is marked flatulency, gas being discharged both by the bowel and by the mouth. The bowels have been constipated, and he has found it necessary from time to time to take a laxative. He has lost flesh and strength and has become very weak and pale.

He was admitted to the hospital nine days ago. On examination we find a man with a long, narrow chest, with imperfect expansion at its upper part. There are, however, no physical signs of disease either of the heart or of the lungs. The belly is scaphoid. On palpation, I find no evidence of induration at any point. The area of hepatic dullness is normal, the spleen is not increased in size. There is rather excessive pulsation of the abdominal aorta, but this is due to the great emaciation and retraction of the abdominal walls. At one point in the abdomen I feel a little body not larger than the least joint of the little finger. This feels like a small gland. It is probably of no importance, and could not be detected if it were not for the great emaciation, which enables me to feel the segments of the vertebral column with the greatest ease. When he was admitted it was quite evident that the stomach was considerably extended. The tympanitic resonance extended to the lower border of the sixth rib at the left nipple line, and downward to the transverse umbilical line, and laterally from the left axillary line to the right costal margin.

As soon as he was admitted he was placed upon the use of peptonized milk, and has not vomited since. He feels better and looks better. Enumeration of the red corpuscles of the blood gives 4,600,000 per millimetre. The hæmoglobin is reduced to 65 per cent. of the normal. In addition to the milk he has taken finely minced meat, slightly boiled. The only medication he has received has been the administration of five drops of chloroform with half a drachm of the compound tincture of cardamon four times daily. He has had no fever. The tongue is extraordinarily smooth. There are scarcely any papillæ visible on his tongue.

Here we have a young man, coming from a remarkably healthy family, living in a healthy district, who, six years ago, had an attack of pain in the bowels, with obstruction and fever lasting a week, leaving behind it, so far as we can determine, no organic change. Then his digestion fails. He takes care of himself, he consults physicians and regulates his diet, but fails to get relief. He then leaves his native country, Ireland, and comes to America, where he pursues a healthy occupation and still goes down more or less rapidly until he reaches a degree of emaciation and anæmia which is remarkable. While it is true that each drop of this man's blood contains almost as many red blood globules as it should, it is also true that he is very far from having as many drops of blood in his body as he ought to have. While he has not what might be called qualitative anæmia, he has a high degree of quantitative anæmia. The composition of this man's blood is fairly good. It is 20 per cent. off in red globules and 40 per cent. in hæmoglobin, but I should think that it is more than 50 per cent. off in the quantity. Not only that, but during the past three years there has been almost constant vomiting. During this time he has gone as long as a month without vomiting, and then he has for weeks, in succession, vomited every day, in spite of medical treatment and regulation of the diet.

The first thing that would be suggested by a case of this kind is grave organic diseases. Has he not some malignant disease? The patient has not reached the age at which malignant disease, as a rule, appears. His good family is against it although this joint is not of much diagnostic value. The case has lasted a long time for a case of cancer. It has lasted six years, and for three years has been quite pronounced. The trouble appears to have begun with an acute inflammatory attack, whereas malignant disease begins insidiously. Careful examination has failed to reveal the presence of any tumor or hardness. While the man is very pale, he does not present the cachexia usually found in advanced cancer. Cachexia is, however, so uncertain that it is not of very great diagnostic value. It is valuable when present, but its absence means little or nothing. The matters vomited have consisted chiefly of partially-digested food. The man has never vomited blood. The obstruction of the bowels has not been as great as we should expect to find it where there was cancer of the stomach, causing as frequent vomiting as this man has presented. Usually, there has not been much pain. These symptoms are all against the idea of cancer of the stomach, and the direct physical examination fails to show any hardening or thickening whatsoever, with the exception of this little body, the size of a cherry, which may be a little mass of hardened fæces, or a hardened mesenteric gland. We may, there-fore, dismiss the idea of cancer.

We should, in the second place, naturally think of simple ulcer of the stomach. In regard to that, we cannot be so certain as in regard to the existence of cancer. We cannot assert that this man has not had ulcer of the stomach. This affection occurs, by preference, in young people, and in cases that are anæmic and debilitated, as this man has been. It causes frequent vomiting, but does not produce obstinate obstruction of the bowels; but in ulcer of the stomach there is nearly always considerable pain and this pain is increased by the ingestion of food and by pressure. There is tenderness over the ulcerated spot. The pain and tenderness are often more marked in simple ulcer than they are in cancer. This man has no tenderness, and there has been a marked absence of pain. In the course of ulcer of the stomach, where the vomiting is as frequent as it has been in this instance, some blood is very apt to be brought up. None has been vomited at any time by this man. While, therefore, we cannot assert positively that ulcer of the stomach is not present, yet the symptoms do not point strongly in that direction.

What other condition would explain such long-continued and serious gastric disease? Chronic catarrhal inflammation of the mucous membrane of the stomach would account for it. This is far more common than either cancer or ulcer of the stomach—in fact, it is among the most common affections. It is true that it is usually met with in its milder forms, which we speak of as catarrhal dyspepsia, but it is also true that when chronic catarrhal gastritis is present in a marked form, it produces very grave symptoms indeed. The constant irritation of the stomach, and the resulting weakness of the stomach walls, induces relaxation and tendency to dilatation of the organ, not so certain as where there is mechanical obstruction of the pylorus; but relaxation and dilatation of the stomach is a very common result of chronic gastritis. If the case has lasted a long time, the degree of dilatation may be enormous. At the same time, it is to be noted that the dilatation of the organ, and the interference with its normal secretion, prevents the proper digestion of the food, which undergoes fermentation with the development of gas. The stomach then becomes irritated, and vomiting of partially digested food follows. If the case is one where a good deal of nervous irritation is caused, the stomach becomes sensitive; then the vomiting may become extremely frequent. In other cases, where the stomach is not so irritable, the partially-digested food is passed into the bowel, leading to irritation, flatulency and diarrhœa. The man has had a good deal of vomiting, but not much diarrhœa. The inevitable result of the irritation of the stomach and interference with digestion is loss of flesh, strength and color, until finally the patient reaches a high degree of emaciation, debility and anæmia.

The case is one of extreme chronic catarrh of the stomach, with a high degree of dilatation of that organ. There is one condition which, of late

years, we have learned to look for in connection with cases of this kind, and that is non-malignant obstruction of the pylorus. The irritation of the coats of the stomach may extend to the deeper structures, and the amount of interstitial thickening, followed by contraction, may lead to obstruction of the pylorus. When such is the case, while there is no tumor to be detected, there are other symptoms of pyloric obstruction. There is vomiting and dilatation of the stomach, with a high degree of emaciation, weakness and anæmia, without cancerous cachexia. I dwell upon these points because it has been proved that when this condition exists, and when dietetic and medicinal measures fail to give relief, it is justifiable to open the stomach and dilate the structure of the pylorus. This has been done in a number of cases, where the history has been similar to that which we obtain in this instance, and where the dilatation of the contracted pylorus has been followed by great relief, and in some cases by extraordinary cures. In some cases the operation has resulted fatally. I do not know whether or not it will find a place for itself among the recognized operations of abdominal surgery, but it is one of the procedures which must be considered in a case of this kind, where the evidence points to the existence of pyloric stenosis of non-malignant character.

How are we to determine whether or not such stenosis exists? Only by the effect of treatment; for, as I have said to you, chronic catarrhal gastritis may produce all the symptoms that would be present if the stenosis existed, but in the one case treatment would give relief, while in the other it would have no effect. In treating a case of this kind, the first thing to be borne in mind is that the food should be administered in small quantities, at regular intervals, and should be of such a character as throw the least work upon the diges tive processes. In this case we have employed artificially-digested milk, giving three pints of peptonized milk during the twenty-four hours. The only solid food allowed has been one ounce of boiled, scraped meat. I was anxious to, see the effect of this dietetic treatment influenced as little as possible by the action of drugs, and have, therefore, only given him a little chloroform and a simple carminative. The result of this treatment has been so satisfactory that we shall continue it. The man has not vomited once since admission, and has felt quite comfortable. The development of flatus has been much diminished by the use of peptonized milk, and the gastric tympany has been lessened. As long as the patient continues to improve, this simple treatment will be kept up. —*Polyclinic.*

THE MANAGEMENT AND TREATMENT OF ACUTE BRONCHITIS IN CHILDREN.

By S. Henry Dessau, M.D., Of New York.

Before speaking of the treatment proper, I would like to call your attention to certain hygienic conditions under which the little patient should be placed as well as the adoption of prophylactic measures, which in delicate children is of prime importance. Regarding prophylaxis in bronchitis, nothing can be better than establishing the habit of cold bathing for the infant. This may be carefully regulated by the use at first of sponging with cold water from the head down to the shoulders and spinal column while the child is in the tepid bath. Afterward douches and the whole bath should be given successively as age advances. The cold bathing strengthens the integuments and prepares the body for sudden cold or other atmospheric influences.

Most of our patients, children affected with subacute bronchitis, are not usually considered sick enough to be kept in bed. The youngest ones have to be carried in the nurse's or mother's arms, even if very sick; while the older ones, if sick enough to be kept in bed, are often allowed to remain in their ordinary clothes. I often find among the poorer classes, and occasionally in families of the better class, the little children almost suffocated with the number of clothes they have on, irrespective of the temperature of the weather. I believe such heavy dressing only exposes the child to contract an additional catarrh upon the slightest change of the weather. If the attack is not severe enough to confine the child to the bed, I direct it to be kept in the room in its ordinary dress; but if sick enough to go to bed, the clothes are to be removed, and nothing but the night-dress worn. Infants while sick should be at all times loosely dressed, and when carried about should be wrapped in a light shawl or blanket. It is a commonly received idea that children affected with bronchitis, however slight, should be kept indoors. My experience in a dispensary practice of twelve years in children's diseases has shown me that, except in severe cases, this is not necessary for a prompt recovery, providing always that the child is kept warm by suitable covering while in the open air. In private practice, however, as there is no occasion for the child to go out of doors, it should be kept in the room.

The temperature of the room should be kept at from 65° F. to 70° F., and proper ventilation secured at night by keeping one or more windows drawn down from the top for about eight or ten inches. One great source of all catarrhs in this city, in my opinion, is the intense heat which is kept up in the dwellings during the entire winter. Even in the rooms of tenement houses this is often found to be the case in an extreme degree. The sudden change experienced on going into the street or even another room or hall-way, or coming from the street into the apartment, will inevitably produce the condition of "catching cold." This may be explained, according to Rosenthal, by the superficial blood vessels of the body becoming paralyzed after one has remained for any length of time in an overheated apartment, while the body temperature rises at the same time. If the over-

heated body, with its enormously dilated superficial blood vessels, is now suddenly exposed to cold, the body temperature descends below the normal, and the blood of the superficial parts, so suddenly cooled, courses through the internal organs and cools them of more suddenly than would be the case from the simple influence of cold, without the previous influence of greater heat. This sudden cooling acts as an injurious influence in causing congestion in this or that organ, especially if it is already enfeebled, and hence less resistant. It will always be of advantage, if the attack is in any way severe, to have a certain amount of moisture in the shape of steam diffused through the air of the room. This can be easily done by keeping water boiling over an alcohol stove. The addition of a small quantity of turpentine will be found highly useful and refreshing.

The therapeutics of bronchitis may be regulated according to the order of the tubes involved, and the rise of temperature which accompanies the disease. In mild cases, where the catarrhal process is limited to the larger tubes, and there is very little or no increase of temperature occurring in infants under six months of age. I have found such remedies as the wine of antimony in doses of one-fourth to one-half drop, in combination with the wine of ipecac in doses of one-half to one drop, repeated every hour, prove highly efficacious. Small doses of the golden sulphuret of antimony, one-twentieth of a grain triturated with sugar of milk, and repeated hourly, have also given satisfactory results. A stimulating embrocation, as equal parts of spirits of turpentine and olive oil, applied with a piece of flannel to the back and front of the chest until reddening of the skin is produced, will prove of additional service. In children over six months of age, similarly affected, the dose of the antimonial and ipecac wines should be increased to one drop each. I have also found the tincture of bryonia of the German Pharmacopœia, in doses of one-half to one drop every two hours, of benefit in some cases. In a few persistent cases of subacute bronchitis in older children, the inspissated juice of *Sabal serrulata*, or saw palmetto, has given gratifying results. The dose is from five to twenty drops three times daily. Where there are evidences of a strumous constitution, the emulsion of cod-liver oil, with or without the hypophosphites of lime and soda, will be found all-sufficient.

In severe cases of bronchitis accompanied with an elevation of temperature, and where the medium-sized and smaller tubes are involved, I am in the habit of giving tincture of aconite root in doses of one-half to one drop, according to age, repeated every hour, with the result of reducing the temperature, and establishing resolution. If a spasmodic element of the cough is manifest to any extent, much benefit may be derived from the tincture of belladonna in drop doses, given alternately every hour with the aconite. It will be remembered that in the early stage of inflammation of a mucous membrane the secretion is at first diminished, the membrane becoming dry and swollen. Afterward the secretion is increased in quantity, while at the same time it becomes altered in quality, being viscid and tenacious. Hence in the early stage of an acute bronchitis, where dry, subcrepitant or sonore-sibilant râles are heard, the practice which is often followed, of giving stimulating expectorants, such as the carbonate and muriate of ammonia and squills, in free doses, can only result in aggravating the existing condition.

Much more successful results, in my opinion, will be obtained by giving such remedies as will relieve the congestion and swelling of the mucous membrane, through acting upon the force of pressure of the blood circulation, or by derivative action upon distant organs whose functions are in a measure compensatory in character. Such is the effect of aconite that I have mentioned, and veratrum viride that I have not used. Nitrous ether, which is a depressor of arterial tension, as the other nitrites are known to be, which thus explains its diuretic effort, is a time-honored remedy in bronchitis, and may be cited as representing the latter class. Spirits of Mindererus, from its sudorific action upon the skin, is always indicated. A favorite combination of mine, which has seldom failed to render me valuable service, is: Liq. ammon. acet., f ℥ iv; spts. ether. nit., syr. ipecac., aa f ℥ iss; syr. senegæ, f ℥ j; syr. limonis, f ℥ j. M. ℥ j every three hours. This formula has been published in an incomplete form in Johnson's Formulary of Wood's Library, and I here take occasion to make correction of the error due, no doubt, to the printer's oversight. I am in the habit of employing this formula daily in my practice. Its use is not confined to the treatment of bronchitis alone, for I find it equally serviceable in the whole range of acute pulmonary complaints as occurring in children. I do not regard the small amount of senega present as having an expectorant action, but more, if you like, of a specific effect upon the ciliated columnar epithelium of the bronchial tubes.

I seldom have to resort to opium except in combination with camphor, as in the tr. opii camph., when it is administered in five to ten-drop doses, principally at night, as a sedative for the cough.

Hot poultices of flaxseed, sprinkled on the surface with mustard, made large enough to encircle the entire chest and covered with oil-silk, form an important addition to the treatment of the severer grades of bronchitis. Pieces of tape extending across the shoulders should bet acked to the cloth holding the poultice, in front and behind, to prevent the poultice from slipping down. The effect of the heat and moisture, together with the counter-irritation produced by the mustard, which can be regulated in amount to suit the demands of the case, are unquestionably of the highest benefit. Where the bronchitis has extended to the infundibula and air vesicles, and catharral pneumonia has developed, I have every reason to believe that a continuous mild counter-irritation, with the

flaxseed poultice lightly sprinkled with mustard, has often been the principal means of enabling me to witness the successful termination of my cases. The poultice should be changed about three times during the day and once through the night. Spongio-piline, wrung out with hot water, answers every purpose of the poultice, besides being cleaner and less troublesome to apply; but, being expensive, it can be afforded only by wealthy families. West recommends the spongio-piline to be sprinkled with a stimulating liniment, such as lin. camph. co., ℥ j; tr. canth., tr. opii, aa ʒ ij. M., when it is desired to produce counter-irritation; but I have found the ordinary mustard, lightly sprinkled over the inner surface, do all that was wanted.

When the râles have become soft and bubbling, and not disposed to clear up quickly, I have found three to five drops of a saturated solution of muriate ammonia, given every two hours, have the happiest effect in clearing up the excessive secretion, notwithstanding in some cases evident signs of catarrhal pneumonia were present. It is important, especially in subjects of a scrofulous and rachitic diathesis, to establish a healthy condition of the mucous membrane of the bronchial tubes as soon as possible. In these cases there is a general tendency for some large ronchi to remain scattered over the lungs after the more severe symptoms have disappeared. The administration of tonics, as quinine and iodide of iron, together with cod liver oil, is here clearly indicated. Counter-irritation to the back, in the interscapular space, with tincture of iodine, should be used, as it is also rightly regarded as a valuable means of promoting absorption of the enlarged bronchial glands, which I have shown are likely to exist.

Inhalations have recently been introduced in the treatment of bronchial catarrhs, and have been found to give valuable assistance in hastening a cure. I have had little, if any, experience with them in children, but can see no reason why they might not be effective with those over two years of age. They may be used in the form of steam inhalations from a croup-kettle, the water being medicated with turpentine, terebene, iodine or eucalyptus, or whatever article may be desired. Older children may submit to the use of the hand atomizer, in which the wine of ipecac, as recommended by Ringer, or Dobell's solution, which is alkaline and antiseptic, may be employed.

In those cases where bronchitis occurs together with diarrhœa as the result of changes of temperature, the antimonial wine in drop doses, repeated hourly, will be found to have a decided effect in relieving both affections at the same time. When the bronchitis occurs as a complication of summer diarrhœa, counter-irritation to the chest with the flaxseed and mustard poultice, together with the administration of stimulants, is chiefly to be depended upon. In infants or weakly children, where a tendency to collapse of the lung is apparent, crying should be provoked and encouraged as much as possible, and alcoholic stimulants freely given. In such cases Day advises the child to be laid face downward, as it assists breathing, and prevents the tendency of the secretions to gravitate to posterior and lower surface of lungs. The same author also suggests that when vomiting becomes a troublesome symptom, the medicine be given immediately after a spell, in order that it may have a chance to remain longer in the stomach and some portion of it be absorbed.

Jacobi wisely advises plenty of water as a drink for the purpose of supplying a fluid for the liquefaction of the viscid secretions, and so promoting their easy expulsion. It will also prevent caseous degeneration by keeping the cells bathed in moisture that will hasten absorption.—*College and Clinical Record.*

THE DIETARY OF BRIGHT'S DISEASE.

BY J. MILNER FOTHERGILL, M. D., EDIN., HON. M. D. RUSH, ILL.

The importance of the dietary in Bright's disease is all the greater in that medicines exercise comparatively little influence upon its progress.

The form of Bright's disease here treated is the chronic one, where the kidneys are "granular," "contracted" "gouty" or "cirrhotic." This is a slow development of connective issue (a parenchymatous inflammation) throughout the structure of these organs, which contracting—as is its nature destroys the secreting and tubular portions. Some portions are destroyed as regards function, while others remain normal and uninjured. At last the destruction is so extensive that the kidneys become quite inadequate to carry out their duty, and the organism perishes.

The opinion of the profession (as regards its members under fifty years of age) is that the main cause of this chronic inflammation is the output of urates by the kidneys. Mammalian kidneys have the soluble urea as their form of nitrogenized waste, while urates belong to animals with a three-chambered heart and a solid urine. When, then, the mammalian liver forms this primitive urine the kidneys become injured by casting it out. Long ago Dr. George Johnson, F.R.S., the respected professor of the Practice of Physic at Kin 's College, and a recognized authority on Kidney disease, wrote: "*Renal degeneration is a consequence of the long-continued elimination of the products of faulty digestion through the kidneys.*"

Recognizing, as we do, that under certain circumstances (often mental strain) the liver falls back upon this primitive urinary stuff, it is obvious that the rational plan of meeting the difficulty is to reduce the albuminoid elements of our food to the needs of the organism rather than the cravings of the palate. That bite of solid meat so acceptable to the Anglo-Saxon has led him to cultivate flocks and herds to a point of excellence

unattained by other races. The beef and mutton in other countries will not furnish solid joints; has to be hashed and stewed and made into ragouts in order to be palatable. Even a leg of mutton stuffed with onions is but indifferently good. A "Wiener Schnitzel" is a veal cutlet, and the continental equivalent of our steak and chop—not forgetting *Fillet de Bœuf*. The "plain roast and boiled," the pride of the Anglo-Saxon housewife and cook, are largely responsible for the prevalence of this form of Bright's disease amidst Anglo-Saxon people.

This statement is not rashly hazarded as a specious and ready generalization. It is the outcome of careful thought on the matter.

In England at least the impression exists that simple fare—"plain roast and boiled," is innocuous. It is a murderous fallacy! It is just the abundance of meat—sapid, palatable, readily prepared, stimulating—that is the bane of so many men. It would not be too sweeping a generalization to say that the lady who dines at home is comparatively free from Bright's disease; while the business man who takes his midday meal at a restaurant, and then dines at home in the evening, is the victim of Bright's disease *par excellence*. As he looks down the ménu for his lunch, his eye lights upon dish after dish, in the composition of which lean meat forms the integral factor.

This fact cannot be impressed too distinctly on the mind. To traverse the statement by pointing to the fact that many men notoriously consume large and unusual quantities of such animal food, with apparent impunity, is merely to state that the human liver is in many instances equal to converting into urea the whole surplusage, or *luxus consumption* of albuminoid matter. It leaves unaffected the fact that when the liver is unequal to such complete conversion, and reverts to the formation of urates, it becomes a wise and prudent measure to reduce the albuminoid elements in the dietary to the wants of the body.

There is a strong impression abroad among medical men, who have paid great attention to the subject, that the lean of the larger animals has a stronger tendency in the metabolism of albuminods to form urates than any other forms of albuminoids. This impression must just be taken for what it is worth. It is sufficiently a matter of faith with the writer to inspire conduct, as his butcher realizes to his cost; while the fishmonger and the greengrocer benefit by it.

The *entrées* and made dishes of French cookery are far less pernicious than "the roast beef of old England," and its congeners. They consist to some extent of lean meat, true; but they also contain notable quantities of oil and vegetables.

The man who is held to be the subject of chronic Bright's disease should banish the solid joint from his table; except maybe on Christmas Day. The steak and chop should be indulged in rarely, and when eaten not be devoid of fat. The veal, or rabbit, or beefsteak pie should not be without a due proportion of fat.

The same may be said of the meat pudding, the hash, or the Irish stew, and the currey. He should have one vegetable course at dinner, and, what is more, ought religiously to partake of it.

White meats, as chicken, are less objectionable than brown meats; but, after all, it is but a matter of comparison. One patient obeyed his instructions but grossly violated them in the spirit. He was a blue-blooded Patrician, inheriting an insufficient liver—illustrating the truth of the adage, "the fathers have eaten sour grapes and the children's teeth are set on edge"—whose urine was laden with lithates. Meat being forbidden but fowls permitted, he explained that he "had passed the joint but laid into the turkey," as a gastronomic rule. A sharp attack of articular gout opened his eyes for him.

Of what then should the man with chronic Bright's disease consist?

Breakfast: Oatmeal or hominy porridge, hominy fritters, followed by a little fish with plenty of butter to it; or a slice of fat bacon or pork. Fat, fish and farinaceous matters. Hominy and fat pork for the less affluent.

Lunch or supper: Mashed potatoes well buttered. Other vegetables well buttered. A milk pudding made without an egg. Biscuits of various kinds and butter, with a nip of rich cheese.

Dinner: Soup containing plenty of vegetable matter, broken biscuit, or sago or vermicelli. Cream, in lieu of so much strong stock, should lurk in the soup tureen; especially in white soup. This should be followed by fish in some form; a course of vegetables, as stewed celery, chopped carrots, a boiled onion, leeks, nicely prepared potatoes, as "browned potatoes" à la Marion Harland, asparagus, or "scalloped tomatoes" and corn or "boiled corn." Then should follow apple-bread pudding, Maud's pudding, bread and raisin pudding; and, if the digestion can be trusted, roly-poly pudding, sweet pudding, and fruit pies. Stewed fruit with creeled rice, rice milk, or other milk pudding is good, or better still, cream. Then comes the biscuit, or crackers and butter. Dessert with its many fruits should never be omitted.

The reader who prefers something tasty and piquant will exclaim this is too much in the "baby-food," or the "nursery line," for him, and asks for some game, or some toasted cheese. Well! in strict moderation let it be—as the tasting of forbidden fruit.

Where something more sapid is fancied let it be anchovy toast, herrings skinned, cut into inch lengths and fried on toast, sardines on toast; possibly, a little caviare, herring roes and millets, or mushrooms. Certainly Pate de Foie Gras—all prejudices to the contrary notwithstanding.

There is a great deal of toothsome eating in a dietary suitable for a man of Bright's disease, all the same.

Eggs, ordinary cheese, and fish roes, are all highly albuminous, it must be remembered.

Fowls, chicken, game, are meats less objec-

tionable than joints; but again it is a matter of comparison.

From what has been stated above, it is clear that "hotel dietary" is as unsuitable for the person with Bright's disease as it is to the dyspeptic. Travel is not prudent for either. They had better keep to a private house with cookery adapted to their special wants.

Then as to drink. The interest in the matter centres round alcohol. Other than alcoholic beverages are beyond contention; except, perhaps, milk, which contains a notable proportion of albumen in the form of caseine. If it be taken as a beverage, or as a food adjunct, its composition must be borne in mind, and the other foods be sparing in albumen.

Probably light wines are practically innocuous, that is in moderate quantities; as is cider. Possibly the same may be said of the light lager beers, as Pilsener, but ales brewed on the English plan exercise a malign influence upon the liver. This applies to the porter and stout. Then as to spirits and waters, aerated or other! Opinions may differ. There is much less Bright's disease in Scotland, where oatmeal porridge and whiskey go together, than in England, with its beef and beer. The reader can draw the inference.

There is no valid proof that alcohol in moderation tends to add further to the morbid process, which, bit by bit, is slowly and insidiously working the ruin of the kidneys. On the other hand, beef-tea often does much mischief. The meat extractives it contains, though not food, are at the head of the descending series, ending in uric acid and urea, and add to the work of the kidneys.

One exquisite beverage, palatable and nutritive, is made with some malt extract and aerated water. Unfortunately, in order to prevent fermentation, a malt extract has to be reduced to the consistency of tracle. This viscidity renders it most troublesome to handle. The readiest plan is to get the cook every morning, or second morning, to dilute a certain amount of malt extract with an equal quantity of warm water, and beat it to a syrup. Fill a tumbler one-third full with the malt syrup, then fill with aerated water. This is a glorious malt liquor for a teetotaller—or any other man!—*Journal of Reconstructives.*

THE TREATMENT OF EPISTAXIS.

By Charles H. Wade, B. A., Oxon., L.R.C.P. Lond., M.R.C.S. Eng.

The embarrassment too often created by the persistence with which hæmorrhage from the nose continues in some cases, notwithstanding that resort is had to the extreme course of plugging the nares, renders any suggestion for effectually controlling this accident acceptable to practitioners. Its occurrence, moreover, not unfrequently takes place under circumstances that tend to increase the concern naturally aroused by loss of blood so alarming in extent as in many instances it is; very often the surgeon is hurriedly called in to arrest the flow without having been informed of the nature of the illness he is about to attend, and he is consequently unprovided with the special appliances deemed necessary for meeting such an emergency, and this, it may be, at a distance from home much too great to allow of any steps on his part towards procuring the means of easily making and placing in position the plugs with which, as a rule, he would seek to put an end to the bleeding. This question has recently been under discussion at the Paris Academy of Medicine, before which body M. Verneuil has described a method that he is disposed to regard as specific in even grave cases, and which consists in applying over the region of the liver a counter irritant in the form of a large blister; and he narrated three cases in which this plan of treatment effectually arrested the epistaxis, even after trial with digitalis, ergotine, and plugging had been made in vain. However successful the proceeding may be, it is impossible to regard it as less than a severe remedy, and if a simpler one should prove to be attended with equally good results, the choice, in ordinary cases, would most certainly lie with it. And that such is the case I am led to think from the good effects obtained by adopting a mode of treatment in these cases for a knowledge of which I am indebted to Mr. Jonathan Hutchinson, who has found it equal to the needs of all occasions on which he has employed it. It consists in immersing the feet and legs of the patient as far as possible, in water as hot as can be borne; and I can assert from experience that whoever will make a trial of the method will have cause to be thankful for so ready and available a remedy in trying emergencies.

A case in point occurred to me on the evening of Christmas Day, 1886, when, about 8 o'clock, I was hastily summoned to attend a laborer, æt. 40, who, according to the messenger, was "bleeding to death." I found him seated on a chair before a large fire, in the kitchen of his cottage, holding a duster, already saturated with blood, to his nose, and surrounded by sympathising relatives and friends; while hard by were evidences, in the shape of blood-stained rags, and a bowl of reddened water, to the effect that the hæmorrhage had been continuing for a considerable time. On inquiry I learned that it had lasted from about one o'clock in the day, and the sufferer himself volunteered the information that his condition might have been influenced by the fact that, in deference to the season, he had taken "his beer" in more liberal quantities than usual. On removing the cloth with which he sought to stay the flow, the blood dripped freely, and the same rate was said to have been maintained for several hours. The man's appearance quite justifiedt he truth of this assertion, and I determined at once to fall back on the hot pediluvium, having, from prior experience, complete faith in its efficacy. Fortunately a pan of water was on the fire at the time, almost

boiling, and half filling a couple of buckets with it, and adding enough cold water to render the bath tolerable, I placed a foot and leg of the patient in each. I must admit that my proceedings up to this point did not perceptibly impress my audience with a sense of my dignity as a surgeon, but almost immediately there after the drop, drop, from the nose of the patient was arrested, and within eight minutes it had entirely ceased. It need hardly be said that he had previously, at my request, been lifted in his chair, from out of the direct head of the fire to a cooler situation, and as he showted a tendency to faintness he was also for a time supported by bystanders who quickly became interested in the virtues of hot bathing as a specific for epistaxis.

Having directed the treatment to be continued for half an hour, and instructed the friends to put the patient then to bed, with the head lying low, I left the case quite easy in my mind regarding it, having first, however, told the wife, an intelligent woman, to repeat the bath should the bleeding return during the night. As a precautionary measure also, a mixture containing iron alum was given at intervals during the succeeding twenty-four hours, and after that the headache and weakness were speeedily recovered from with the aid of a tonic and good feeding. Once only, on the day following that of the attack, did the hæmorrhage recur, and it was at once and completely arrested by the same means.

I do not hesitate to describe this case at length because it illustrates a class of accidents more common perhaps in general practice than under any other circumstances; and also because they often give a good deal of trouble and cause much anxiety to those having the treatment of them. Since the time named I have more than once had occasion to adopt the same course of procedure, and in one instance being called late at night to a patient some miles away, and being unable to go to him at once, I gave the messenger careful instructions what to do; and the next day had the satisfaction of learning that all had gone well, though the hæmorrhage had lasted more than twelve hours.

It is not difficult to understand the *modus operandi* of the treatment, the success of which clearly depends on the abstraction of blood from the head owing to the greater demand for it in the lower extremities under the influence of the hot water. Moreover, it is probable that the force of the outflowing stream through the nostrils being once diminished, that coagulation is encouraged in the nasal vessels as a consequence of the loss already sustained, for the tendency, even in obstinate cases of epistaxis, is undoubtedly to the production of clot after a certain period in the process of bleeding. The frequent uselessness of hæmostatics during the flow also points to the same conclusion; for these agents act readily enough when once the loss of blood is arrested, they fail earlier because the effect of their local action is undone by the persistence of a current past the points affected, but which current is slowed or even stopped when a new demand for largely increased supplies of blood is set up in a more dependent part of the body.

It is impossible not to see in the plan of M. Verneuil a close relation to the one I have endeavored to describe, though the latter has many elements of advantage to recommend a preference for it, at any rate, at first. Whatever opinion may be held as to its mode of action, however, there can be no question of its extreme value as a mode of controlling epistaxis. It is sufficiently simple to be tried in all cases; it will rarely or never fail.—*Medical Press.*

THE TREATMENT OF DIABETES.

A paper was recently read before the Académie des Sciences, at Paris, by M. Villemin, on a case of acute diabetes which had been treated by means of opium and belladonna combined. The patient was a young soldier, strongly built and hitherto of good health, who had suddenly developed intense diabetes, passing twenty-five pints of urine daily with near two pounds of sugar. Two grains of extract of belladonna with one grain of extract of opium were then given, the patient at the same time being restricted to the usual *régime* for diabetic patients. In the course of a fortnight the quantity of urine was not much above normal, and the sugar had disappeared. Discontinuance of the treatment, even though the same diet was adhered to, was promptly followed by a return of the symptoms, which, however, as promptly subsided when the treatment was resumed. Later on he was allowed to return to the ordinary full diet for non-diabetic patients, but even then, so long as the opium and belladonna treatment (raised to 3 grains daily of each) was continued, no return of the polyuria or glycosuria occurred. Under treatment the patient gained 18 pounds in weight. Without being over-saguine, it would be interesting to see the result of this treatment in other hands.—*Dub. Medical Press.*

ŒDEMA OF THE PREPUCE.

Dr. J. G. Tapper writes to the *New York Medical Journal* for November 6, 1886, that for several years past he has been treating very successfully the great œdema and infiltration, attending many cases of phimosis and paraphimosis as the result of congenital or specific causes. In many cases occurring in the adult we find a perfect horror of being confined to the bed. In fact, unpleasant circumstances connected with the trouble render it imperative that our patient should engage in his usual occupation during the treatment. These requirements have led him to the adoption of the following measures: He saturates a given quantity of absorbent cotton with chemically pure glycerin

in which bichloride of mercury has been dissolved in proportions varying from 1 in 1000 to 1 in 5000, according to the amount of fœtor present; or, in place of the bichloride, iodoform, carbolic acid, or any antiseptic agent preferred may be used. With the cotton so charged he completely encircles the organ so far as it is involved. Over this a large rubber condom is drawn, which is then suspended from an abdominal band. This dressing is to be repeated every six hours until the œdematous condition disappears. At that time a beginning pallor will be observed, and often in from twelve to twenty hours the prepuce will have become very pale and shrivelled. The great majority of cases yield promptly, and no further progress is observed after the first application. If ulcers are present, it will often be discovered that they have taken on a healthy action before it has been possible to expose them, and not infrequently this progresses until the cure is completed. The advantages of this dressing are: it is cleanly; there is no difficulty in applying it, patients frequently continuing the treatment at their rooms or places of business after the first dressing; it does not expose or confine the patient; and the results in his hands, and in those of others who have tried it at his suggestion, have been very satisfactory.—*Therapeutic Gazette.*

ERGOT IN ERYSIPELAS.

One of the most unsatisfactory processes to deal with on account of the want of success attending our efforts, is that of rapidly spreading erysipelatous inflammation. It is often found to be the case, that a focal point existed early in the disease, from whence the redness and accompanying tenderness spread rapidly, until large areas of skin were involved, and danger to life was imminent. In these, as well as others presenting features less marked, in which the tendency to spread is less pronounced, many local remedies have been applied, with varying success, and almost uniform reports as to their efficacy. This last is perhaps due to the fact that most of the cases of erysipelas are favorably influenced by iron, given internally, generally in the form of the muriated tincture, and which treatment is nearly invariably pursued. A local application which is never mentioned in text-books or papers, at least it has escaped our notice if it is, but which has proved to be of the greatest practical value in one of the large institutions of this city, is the Fluid Extract of Ergot. This remedy, which answers all theoretical as well as practical purposes, has been found to far surpass all other local remedies in the treatment of this affection in this institution, at which we had an opportunity of seeing it constantly used for a year, in a ward, set apart for those cases, which was never vacant. It is painted on with a brush quite thickly, and rapidly dries, protecting the skin from the air, and besides, answering the theoretical purpose of contracting the gorged capillaries. Success with this procedure was so pronounced and uniform, that nothing was ever used in its place, the case being treated with the full confidence in its powers to allay the pathological process gained by repeated success.—*St. Louis Medical Review.*

A good motto, "In certis unitas, in dubitas libertas, in omnibus charitas," in that which is proven let us have unity, in doubtful things let us have liberty, in all things let us have charity.

TO STOP TOOTHACHE.

Gesell-Fels makes the following mixture, which is an oily liquid, and introduced in the tooth cavity has proved very effective:

Camphor, gr. lxxv;
Chloral hydrati, gr. lxxv;
Cocaini muriat., gr. xv.

PRESCRIPTION FOR HEADACHE.

The following is from Dujardin-Beaumetz:

Ethoxycafeine, gr. xii;
Sodii salicylat, gr. xv;
Aquæ destill., ad ℥ i.

Dose.—Teaspoonful or tablespoonful.

THE CANADA MEDICAL RECORD.
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MONTREAL, JULY, 1887.

ANNUAL MEETING OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.

The annual meeting of the Council of the above body was held in the Examination Hall of the Ontario College of Pharmacy, in this city, on June 14th and following days. Dr. H. H. Wright in the chair. The election resulted in the appointment of Dr. Henderson to the presidency, with Dr. Burns, vice-president. The offices of registrar and treasurer were continued to Drs. Pyne and Aikins.

CANADA MEDICAL ASSOCIATION.

This Association holds its annual meeting at Hamilton on the last day of August and the 1st of September. We trust the attendance will be large. We are glad to know that notwithstanding the attractions of the International Medical Congress at Washington a few days later, Montreal will be fully and ably represented. We predict a successful and a useful session.

INTERNATIONAL MEDICAL CONGRESS.

On the 5th of September, this assembly long looked forward to, with various feelings, by the different sections of the Medical profession in the United States, will open at Washington. Notwithstanding the bitter feelings, which have been the outcome of the division which took place among its promoters, in its early history, the attendance promises to be large, and influential—though not so much so as unanimity would have secured. Prominent men from abroad, and from the United States, whose presence was most desirable, will be absent; yet, others, possibly as earnest workers, have intimated their intention of taking part. Montreal will also be well represented at this Congress—although even here, the division, so to speak, compels, as a matter of propriety, the absence of some. Reduced rates are offered by the various railways.

THE ENGLISH COMMISSION ON PASTEUR'S METHOD OF PREVENTING OR TREATING HYDROPHOBIA.

The British Parliamentary Commission, which has been engaged in the study of Pasteur's work for several years, has finally presented a report, which expresses confidence in the truth of Pasteur's claims with regard (1) to the presence of hydrophobia virus in the spinal cord of animals dying with the disease, (2) to its transmissibility to other animals by inoculation, (3) to the fact that animals can thus be rendered refractory to subsequent inoculations, or even the bites of rabid animals. Finally, it is highly probable, even after such bites have been inflicted upon unprotected subjects, that subsequent inoculation as practised by Pasteur is of service in preventing the development of the disease.

The committee observe, "Making a fair allowance for uncertainties and other questions which cannot now be settled, we believe it sure that, excluding deaths after bites by rabid wolves, the proportion of deaths in the two thousand six hundred and eighty-two persons bitten by other animals was between 1 and 1.2 per cent., a proportion far lower than the lowest ever estimated among those not submitted to M. Pasteur's treatment, showing, even at this lowest estimate, a saving of not less than one hundred lives."

The value of M. Pasteur's method is further confirmed by the results obtained in certain groups of his cases. Of two hundred and thirty-three persons bitten by animals in which rabies was proved, either by inoculation from their spinal cords or by the occurrence of rabies in other animals or persons bitten by them, only four died. Without inoculation it is more than probable that at least forty would have died. Further illustration of this successful result is shown among other additional groups of cases. Between the end of last December and the end of March, M. Pasteur inoculated five hundred and nine persons bitten by animals proved to be rabid, either by inoculation from their spinal cords or by the death of some of those bitten by them, or as reported on by veterinary surgeons. Of this number only two have died. One of these was bitten by a wolf a month before inoculation, and died after only three days' treatment. If we omit say one-half of these cases as being too recent, the other two hundred and fifty have had a mortality of less than one per cent., instead of twenty to thirty per cent.

"From the evidence of all these facts," the committee then say, "we think it certain that the inoculations practised by Mr. Pasteur on persons bitten by rabid animals have prevented the occurrence of hydrophobia in the large proportion of those who, if they had not been so inoculated, would have died of that disease; and we believe that the value of his discovery will be found much greater than can be estimated by its present utility, for it shows a method of inoculation by which it may be possible to avert after infection other diseases besides hydrophobia. His researches have also added very largely to the knowledge of this disease, and have supplied what is of the highest practical value,—namely, a sure means of determining whether an animal that has died under a suspicion of rabies was affected really with the disease or not."

BEECHER'S VOICE IN THE PHONOGRAPH.

The *Philadelphia Medical and Surgical Reporter* says: In the house of Thomas A. Edison, at Llewellyn Park, is a remarkable memento of Beecher. The inventor's phonograph for impressing on a soft metal sheet the utterances of the human voice, and then emitting it again by the turning of a crank, has never been put to any very valuable use, and Edison has only gathered from it a few thousand dollars in royalties from exhibitors. But he utilized it to make a collection of famous voices. Since he became famous his visitors have included hundreds of celebrities. Instead of asking them for their autographs or photographs, he has in two or three hundred instances requested them to speak a few sentences into a phonograph. He has kept the plates in a cabinet, and occasionally he runs some of them through the machine, which sends out the words exactly as uttered. Edison is probably the only man who can revive the silenced voice of the great preacher.

PERSONAL.

Dr. Roddick, Professor of Clinical Surgery in McGill University, is about to visit Europe for the benefit of his health.

Dr. George Ross, Professor of Clinical Medicine in McGill University, whose illness we mentioned some two months ago, is now at Rye Beach. His numerous friends will be pleased to know that he continues steadily to improve, and that there is every probability that by September he will be so completely recovered, as to justify him in resuming active work.

Dr. Sterling (M.D.), Edinburgh, has settled in Montreal as an Oculist.

Dr. Apostoli, the celebrated French Gynecologist, is, we learn, to pay Montreal a visit while *en route* to the International Congress at Washington. Dr. A. Lapthorn Smith, of the Faculty of Medicine of Bishops' College, has been engaged by Dr. Apostoli to translate his forthcoming work into the English language.

Dr. Laberge, the Montreal Health officer, is undergoing a kind of periodical castigation at the present time. His treatment is rather harsh, and while, perhaps, not faultless, he has not been the listless idler his opponents would like to make him out.

REVIEW.

A Practical Treatise on Obstetrics. In four volumes. Vol. I, Anatomy of the Internal and External Genitals, Physiological Phenomena (Menstruation and Fecundation). Vol. II, The Pathology of Pregnancy. Vol. III, The Pathology of Labor. Vol. IV, Obstetric Operations, The Pathology of the Puerperium. By A. Charpentier, M.D., Paris. Illustrated with lithographic plates and wood engravings. These are Vols. I, II, III and IV of the "Cyclopedia of Obstetrics and Gynecology" (12 volumes), issued monthly during 1887. New York: Wm. Wood & Co. Price of the set $16.50.

We congratulate the editor and publishers on the selection of Charpentier's work to represent the obstetric portion of their Cyclopedia. The editor, Dr. E. H. Grandin, has assuredly done his work well, and, in giving the book an English dress, has very properly placed in brackets the views held by the profession here, where they differed materially from the French text. An example of this may be found in the chapter containing a description of the third stage of labor. Dr. Charpentier advises traction on the cord, giving minute details as to the direction, etc, Dr. Grandin adds a description of Crede's method, and very properly adds that it is the accepted practice in this country. In another part of the work, however, we think the text could have been improved upon by making the positions of the child in delivery correspond to that usually given by English and American authors.

There is nothing more confusing to the student of medicine than to find that every obstetrical work he picks up gives different names to the different positions. When there is no special advantage to be derived from any special nomenclature, we certainly ought to try to confine ourselves to one for the sake of simplicity.

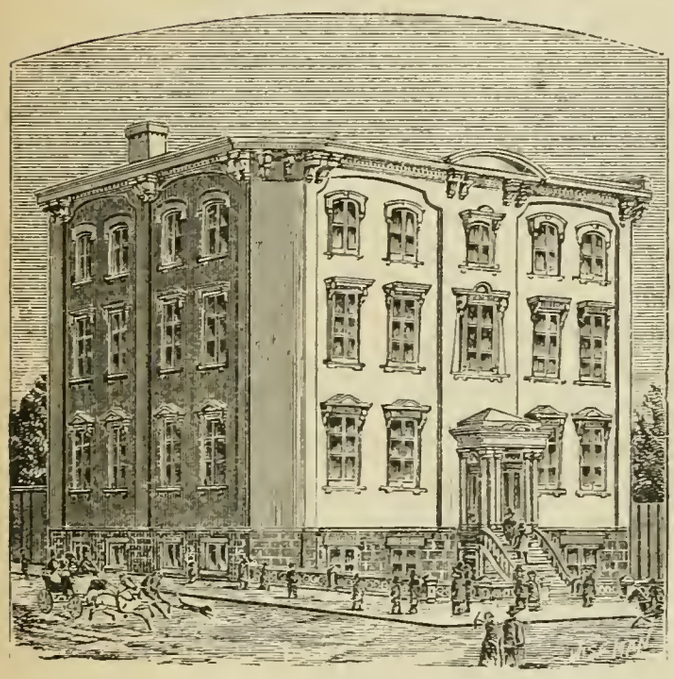
Volume four completes Charpentier's great work, and gives us the most interesting part of all. The variety of forceps described is very large, from the original one of the Chamberlen's to the latest modification of Tarnier's. All the obstetric operations are minutely described and profusely illustrated, but the wood-cuts are not as distinct as they might have been; this, no doubt, being due to the small cost of the work, so as to bring the price within the reach of all practitioners. Puerperal fever is regarded as merely puerperal septicæmia, and the author is an extreme advocate of antiseptic obstetrics, including the post partum vaginal injections in all cases. The rest of the book is admirable, especially the chapters on dystocia. The work is one intended more for the use of practitioners than for students.

UNIVERSITY OF BISHOP'S COLLEGE

MONTREAL.

FACULTY OF MEDICINE.

SESSION OF 1887-88.



THE SEVENTEENTH WINTER SESSION

Of this Faculty will open on Tuesday, the fourth day of October, 1887.

The Faculty of Medicine of Bishop's College aim at imparting a thoroughly practical medical education, and their facilities for doing so are in many respects unequalled in Canada. In addition to the regular courses of didactic lectures, students have the advantage of extensive and varied hospital privileges.

Its Diploma is recognized by the Royal College of Physicians, Edinburgh, Royal College of Surgeons, Edinburgh, the Royal College of Surgeons, England, the Royal College of Physicians, London and the Faculty of Physicians and Surgeons, Glasgow.

Students have the option of attending the practice of either the Montreal General Hospital (200 beds), or of the Hotel Dieu Hospital (200 beds), both of which Institutions have a staff who regularly and systematically visit them. At the Montreal General Hospital excellent facilities are afforded for the study of Practical Pathology, under the direction of the Pathologist of the Hospital. The practice of the Montreal Dispensary—where splendid opportunity is afforded to learn Dispensing—is open to the Students of Bishop's College.

The Woman's Hospital, under the Supervision of this Faculty, is divided into two Departments—Obstetrical and Gynecological. The Obstetrical Department is under th . control of the Professor of Midwifery, and affords to Students a field unequalled in the Dominion—in fact this Department has made Bishop's College the Midwifery School of Canada. The Gynecological Department is attended by the Professors of Bishop's College, and is the only Hospital of its kind in the Dominion. Opportunity is here afforded to see most of the operations in this important Department of Surgery.

Two Gold Medals ("The Wood" and the "Robert Nelson" Gold Medals) and the "Dr. David" Scholarship, are competed for annually.

Fees, about the same as at the other Medical Schools in Canada, but a Student who pays the cost of the entire course on the commencement of his studies can effect considerable reduction.

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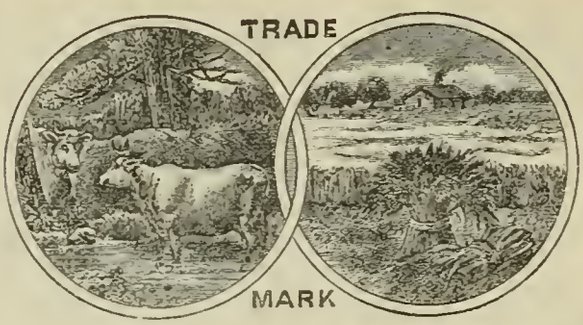

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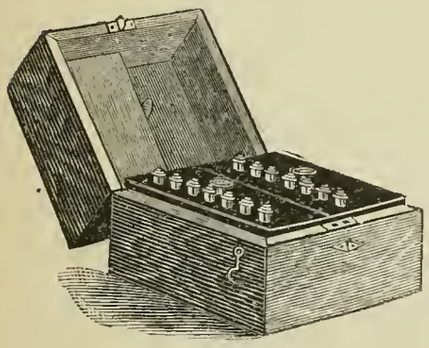

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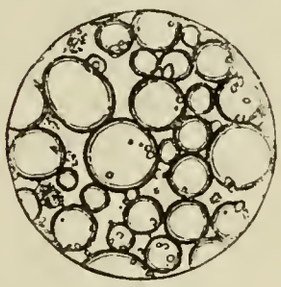

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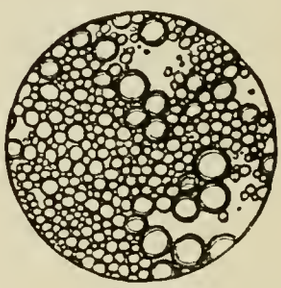

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